Banff Sport Medicine

SHOULDER: Initial Consult
PATIENT HISTORY

☐ Dr. M. Heard
☐ Dr. G. Buchko
☐ Dr. L. Hiemstra

PATIENT NAME: _____ Date _____

Symptoms / Injury Description

Which SHOULDER are you being seen for today? ☐ Right ☐ Left ☐ Both

Did your problem come on gradually or as a result of an injury? ☐ Gradually Date of onset: _____

☐ Injury Date of injury: _____

Describe what happened: _____

_____

The main problem is? ☐ Pain ☐ Instability ☐ Stiffness ☐ Weakness ☐ Other _____

Rate your shoulder problem during the last month (CIRCLE): (no problem) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Does your shoulder wake you up at night? ☐ Yes ☐ No

What, if anything, makes your shoulder worse? _____

What, if anything, makes your shoulder better? _____

Sports / Recreation

List your regular sports/recreation activities:

1. _____ ☐ Recreational ☐ Amateur Competitive ☐ Professional Competitive ☐ Other _____

2. _____ ☐ Recreational ☐ Amateur Competitive ☐ Professional Competitive ☐ Other _____

Previous Surgery / Treatments / Tests

Have you had previous?:

RIGHT: Shoulder **injuries?** ☐ Yes ☐ No	**LEFT:** Shoulder **injuries?** ☐ Yes ☐ No
Describe:	Describe:
When?	When?
RIGHT: Shoulder **surgeries?** ☐ Yes ☐ No	**LEFT:** Shoulder **surgeries?** ☐ Yes ☐ No
Describe:	Describe:
When?	When?

What treatment(s) have you had for your shoulder? ☐ Nothing ☐ Physiotherapy ☐ Medication ☐ Injections

☐ Sling ☐ Surgery ☐ Other: _____

What tests have you had done for your shoulder? ☐ X-ray ☐ MRI ☐ CT scan ☐ Ultrasound ☐ Bone Scan

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