DANIEL F. HABER, M.D.
221 E.HACIENDA AVE. SUITE C
CAMPBELL, CA 95008
408-374-5700

Shoulder Information Forms - General Information

We would appreciate your volunteering some information about you and your shoulder to help us in its evaluation and treatment. Your complete answers to the information below will be helpful; however, you should feel free not to respond to any of the, questions that you find objectionable. Please use the back sides of the pages as necessary.

Your Name: _____
Address: _____
Phone: _____
Next of Kin: _____
Address: _____
Phone: _____
Date of Birth: _____ Today's Date: _____
Referring Physician
Name: _____
Address: _____
Phone: _____
Family/General Physician
Name: _____
Address: _____
Phone: _____
Occupation: _____
Date Last Worked _____
Usual recreation: _____
Date last able to do this recreation: _____
Right handed: _____ **Left handed**: _____
Shoulder involved: Right _____ Left _____
Date your shoulder problem began: _____
Were you hurt on the job? _____
Does your shoulder problem involve a legal case? _____
Please describe your current shoulder problem in your own words:

If you had an injury, please describe it in detail:
_____
Do you currently have problems with any of the below? If so, please describe them.
Shoulder stiffness: _____
Shoulder weakness: _____
Shoulder instability: _____

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Simple Shoulder Test

Please answer these questions about your shoulder.

	YES / NO
1. Is your shoulder comfortable with your arm at rest by your side?	◯ / ◯
2. Does your shoulder allow you so sleep comfortably?	◯ / ◯
3. Can you reach the small of your back to tuck in your shirt?	◯ / ◯
4. Can you place your hand behind your head with the elbow straight out to the side?	◯ / ◯
5. Can you place a coin on 8 shelf at the level of your shoulder without bending your elbow?	◯ / ◯
6. Can you lift 1 pound (8 full pint container) to the level of your shoulder without Bending your elbow?	◯ / ◯
7. Can you lift 8 pounds (a full gallon container) to the level of the top of your head Without bending your elbow?	◯ / ◯
8. Can you carry 20 pounds (a bag of potatoes) at your side with the affected extremity?	◯ / ◯
9. Do you think you can toss a softball underhand 10 yards with the affected extremity?	◯ / ◯
10. Do you think you can throw a softball overhand 20 yards with the affected extremity?	◯ / ◯
11. Can you wash the back of your opposite shoulder with the affected extremity?	◯ / ◯
12. Would your shoulder allow you to work full-time at your regular job?	◯ / ◯

Are there other important things you cannot do as a result of your shoulder problem?

_____

Please list any previous doctors you have seen about your shoulder problem:

_____

Please list any previous tests you have had concerning your shoulder problem:

_____

Please list any previous nonmedical treatment you have had for your shoulder problem:

_____

How many cortisone, steroid, or other type of injections have you had in your shoulder?

_____

Please list any previous shoulder surgeries; which shoulder, the procedure and date:

_____

Are there any other aspects of your shoulder problems that we should know about?

_____

Is there any family history of shoulder problems?

_____

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Shoulder Information Form General Health

The following information will help us understand your overall health and how it may relate to your shoulder problem.

Do you have any problems with joints other than the shoulder discussed above? _____
If so, please describe them: _____

Have you had any surgeries other than those listed above? _____
If so, please list them: _____

Have you had infections, bleeding, or any other complications from previous surgeries? _____
If so, please explain: _____

Do you have a family history of health problems? _____
If so, please explain: _____

Are you a smoker? _____ Packs per day? _____ Years of smoking? _____

Alcohol consumption per average day? _____

Have you ever used recreational drugs? _____

Do you have allergies? _____

Please list your current medications; including aspirin, antacids, pain medicines, and heart, lung or kidney medicines: _____

Do you have any of the health concerns listed below? If yes, please describe:

Heart_____
Lungs_____
Seizures_____
Kidneys, bladder_____
Depression_____
Tendencies for infection_____
Exposure to hepatitis_____
Exposure to my infections (AIDS)_____
Exposure to TB infection_____

	YES / NO
Do you have a lot of body pain?	◯ / ◯
Do you feel good most of the time?	◯ / ◯
Do you get depressed sometimes?	◯ / ◯
Do you feel your health is likely to get better?	◯ / ◯
Do you have as much energy as others?	◯ / ◯

Are there any other health-related factors we should know about? If yes, please explain: _____
_____

_____ _____
Signature Date