

PATIENT INFORMATION (please fill out before your visit): Your Primary Care MD _____

Your Name: _____ Your Age: _____

Any changes in medical history? _____

1. Which shoulder bothers you today? RIGHT LEFT BOTH NEITHER
2. How has your shoulder progressed since last visit? BETTER WORSE SAME **Percent of normal** _____%
3. Where is your shoulder pain located? BACK FRONT SIDE DEEP ARM ARMPIT _____
4. How would you describe the pain? ACHING BURNING SHARP DULL IRRITATING _____
5. How SEVERE is the pain, on a scale of 0 (no pain) to 10 (worst pain ever)? _____
6. How long does the pain last, and when does it occur? _____
7. What makes the pain better? _____ Worse? _____
8. What medicines are you taking for the pain, and how much/often? (please list all specific medicines and doses) _____
9. Any numbness or tingling? If yes, where? _____ Any fevers, night sweats or chills? _____
10. Any other comments or things we should know? _____

Your signature and date please: _____

PHYSICIAN/PA EXAMINATION (for physician only) F/U S/P R L B

___ A&O x 4, appropriate, ambulates normally. ___ Skin no lesions/signs infection/incisions healed/sutures

R L B Elbow/ Wrist/ Fingers AROM full without crepitation/weakness/instability R L B Fingers NVI M/S M/R/U

R L B Elbow AROM/PROM Flexion-Exten Arc _____ PRO _____ Sup _____

R L B Shoulder AROM full without crepitation/weakness/instability with exception of _____

R L B Shoulder AROM/PROM FF _____ AB _____ ERO _____ IR _____

R L B Tenderness at ACJ LHB LT GT None _____ Relocation _____
Apprehension _____ O'Brien _____ LO _____ BP _____

R/L/B Sh Strength testing (out of 5) FF _____ AB _____ JobesAB _____ ERO _____ IR _____

OTHER FINDINGS _____

NOTES _____

Imaging: _____

A / P: _____ F/U _____

Approximately _____ minutes or longer was spent with the patient today, over half of this was spent counseling the patient regarding their findings and options for treatment

Provider Signature/Date: _____

Shoulder Arthroplasty Pre-op

Strength Test: R _____ L _____ lbs
(Indicate "0" if patient cannot reach 90° FF)

External Rotation:

- R L
- / None of the movements are pain free
 - / Hand behind head & elbow forward
 - / Hand behind head & elbow back
 - / Hand above head & elbow forward
 - / Hand above head & elbow back
 - / Full elevation of arm

SPOT – Subjective Patient Outcome Tracker

DATE: ___/___/___

NAME: _____

MRN: _____

For the following questions, please indicate what percent satisfaction you have regarding **BOTH** of your **SHOULDERS**

0% = TERRIBLE/Not satisfied at all **100% = GREAT/Completely satisfied**

(Or **choose A NUMBER between 0 and 100** to show your level of satisfaction)

<p>1. How satisfied are you with the comfort (lack of pain) in your shoulder when you are not using it?</p> <p>Right <input type="text"/> % Left <input type="text"/> %</p> <p>2. How satisfied are you with the comfort (lack of pain) in your shoulder during or after activity? (e.g. work, school, chores, sports)</p> <p>Right <input type="text"/> % Left <input type="text"/> %</p> <p>3. How satisfied are you with your ability to sleep through the night without your shoulder bothering you?</p> <p>Right <input type="text"/> % Left <input type="text"/> %</p> <p>4. How satisfied are you with the mobility ('range-of-motion') of your shoulder?</p> <p>Right <input type="text"/> % Left <input type="text"/> %</p> <p>5. How satisfied are you with the stability (how secure it feels in its socket) of your shoulder?</p> <p>Right <input type="text"/> % Left <input type="text"/> %</p> <p>6. How satisfied are you with the strength of your shoulder?</p> <p>Right <input type="text"/> % Left <input type="text"/> %</p> <p>7. How satisfied are you with your shoulder's ability to do your regular chores and/or everyday activities?</p> <p>Right <input type="text"/> % Left <input type="text"/> %</p> <p>8. How satisfied are you with your shoulder's ability to do your regular work activities? (write N/A if you do not work or are retired)</p> <p>Right <input type="text"/> % Left <input type="text"/> %</p> <p>9. How satisfied are you with your shoulder's ability when you do your regular fitness/exercises/sports? (write N/A if this does not apply)</p> <p>Right <input type="text"/> % Left <input type="text"/> %</p> <p>10. How satisfied are you with getting through the day and not feeling worried or frustrated about your shoulder?</p> <p>Right <input type="text"/> % Left <input type="text"/> %</p>

OFFICE USE ONLY

RIGHT:

Non-Operative

Pre-Operative

Post-Operative

Date of Sx: _____

Procedure: _____

LEFT:

Non-Operative

Pre-Operative

Post-Operative

Date of Sx: _____

Procedure: _____

Thank you for completing this questionnaire!