Click on BIG boxes to type in your responses
Click LITTLE boxes to make choices & unclick to change a choice

Sydney Shoulder Specialists

Patient Details

Your Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr ☐ Other: _____

First (given) Names*: _____ Surname*: _____

*must be the same as they appear on your Medicare card if you have one

Date of Birth: _____/_____/_____ Age: ____ Gender: ☐ Male ☐ Female Preferred Name (if any): _____

Address: _____ Mobile Ph: _____

Suburb: _____ Home Ph: _____ Work Ph: _____

State: _____ Postcode: _____ Email: _____@_____

Account to be sent to (ie parent's name if patient is a child): _____

Next of kin: _____ Mobile number: _____

What is your next of kin's relationship to you?: _____

Medicare Number: _____ Your Ref No: _____ Expiry date: ____/____

Private Health Fund: _____ Membership No: _____

Please tick if you have a: ☐ Pension card ☐ Health Care card ☐ Gold DVA card or a ☐ White DVA card

Card number: _____ What is the card's expiry date?: ____/____/____

Referring doctor: _____ Is this doctor is a: ☐ GP or a ☐ Specialist ?

The name of your usual GP (if different from above): _____

GP's address: _____ Phone: _____

Physiotherapist: _____ Phone: _____

Physiotherapist's address: _____

Are you retired? ☐ Yes ☐ Semi ☐ No What is/was your occupation? _____

Sports You Play: _____ Competition sport?: ☐ Yes ☐ No

Workers Compensation or Third Party Claims

Is your consultation related to a claim for: ☐ Workers Compensation? **or** ☐ Third Party? *If yes, please also provide:*

Employer's name: _____ Phone: _____

Address: _____ Fax: _____

Date of Injury: ____/____/____ Insurance Co: _____ Claim No: _____

Address: _____ Fax: _____

Case Manager's name: _____ Direct Ph: _____

Case Manager's Email address: _____@_____

Medication, Allergy and Surgical History

Do you regularly take: ☐ Warfarin ☐ Plavix ☐ Aspirin or ☐ other **blood thinners**: _____

Do you regularly take: ☐ Herbal Medications *If so, which ones*: _____

Do you regularly take: ☐ Pain Medications *If so, which ones*: _____

Other current **medications**: _____

Do you drink any alcohol? ☐ Never ☐ Sometimes ☐ Rarely Number of drinks per ☐ day or ☐ week? _____

Do you have any **drug allergies**? ☐ Yes ☐ No *If yes, which drugs?* _____

What reaction do you have? ☐ Rash ☐ Shortness of Breath ☐ Swelling ☐ Anaphylaxis ☐ other: _____

What else are you allergic to (eg latex, food, dust mites, cats, dogs)?: _____

What reaction do you have? ☐ Rash ☐ Shortness of Breath ☐ Swelling ☐ Anaphylaxis ☐ other: _____

Have you any p**revious surgery**? ☐ Yes ☐ No (*this doesn't just have to be shoulder or elbow surgery – any type*)

Please state type and year performed: _____

_____

Have you ever had **complications** after surgery? ☐ No ☐ Yes If yes, what? _____

_____

Any problems with any **other joints**? ☐ Yes ☐ No If yes, which joints? _____

Medical History

Arthritis:
Osteoarthritis ☐ Yes ☐ No
Rheumatoid Arthritis ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No
- If yes, controlled by? ☐ Diet ☐ Tablet ☐ Insulin

Epilepsy: ☐ Yes ☐ No
- If yes, do you take medication? ☐ Yes ☐ No

Liver Disease:
Hepatitis B or C: ☐ Yes ☐ No

Stroke(s): ☐ Yes ☐ No

Past Blood Transfusion: ☐ Yes ☐ No

HIV / AIDS: ☐ Yes ☐ No

Kidney Conditions: ☐ Yes ☐ No

Cardiac Problems:
- Heart Attack ☐ Yes ☐ No
- High Blood Pressure ☐ Yes ☐ No
- Low Blood Pressure ☐ Yes ☐ No

Other: _____

Gastric Problems:
- Indigestion / Reflux ☐ Yes ☐ No
- Stomach Ulcer ☐ Yes ☐ No

Lung Conditions:
- Asthma ☐ Yes ☐ No
- Smoker ☐ Quit ☐ Yes ☐ Never
- Emphysema ☐ Yes ☐ No
- Sleep Apnoea ☐ Yes ☐ No
- Pulmonary Embolus ☐ Yes ☐ No

Thyroid Conditions:
- Hyper-active ☐ Yes ☐ No
- Hypo-active ☐ Yes ☐ No

Venous Conditions:
- DVT (Thrombosis) ☐ Yes ☐ No
- Varicose Veins ☐ Yes ☐ No

Cancer:
- Breast ☐ Yes ☐ No
- Mastectomy ☐ Yes ☐ No
- Shoulder Region ☐ Yes ☐ No
- Other _____

Shoulder Symptoms

When did they start?: _____/_____/_____ (*approx is OK*)

Which shoulder is it?: ☐ Left ☐ Right OR ☐ Both?

Are you: ☐ Left **handed** ☐ Right **handed** OR ☐ Both?

Did pain/symptoms start ☐ **suddenly** or ☐ **gradually**?

Are the problems you have with your shoulder from an **injury**?: ☐ Yes ☐ No *known* injury ☐ No

Injury Date?: _____/_____/_____ (*approx is OK*)

What **type of injury**?: ☐ fall ☐ sports ☐ bicycle accident ☐ car accident ☐ motorbike accident ☐ work accident ☐ work repetitive injury ☐ another injury or accident:

_____

Do you or have you had any shoulder:
Stiffness? ☐ Yes ☐ No
Weakness? ☐ Yes ☐ No
Dislocations? ☐ Yes ☐ No
↘ If yes, how many have you had? _____

To treat your symptoms have you had any:

Physio? ☐ Yes ☐ No
Injections? ☐ Yes ☐ No *Number?* _____
Surgery? ☐ Yes ☐ No *When?* _____
Type/Name? _____

Have you had any other treatments?: ☐ Yes ☐ No

If yes, what: _____

_____

The Oxford Shoulder Score

To change an answer, unclick the wrong box then click the right one

1 During the past 4 weeks. . .

How would you describe the worst pain you had from your shoulder?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Unbearable

2 During the past 4 weeks. . .

Have you had any trouble dressing yourself because of your shoulder?

☐ No trouble at all ☐ A little bit of trouble ☐ Moderate trouble ☐ Extreme difficulty ☐ Impossible to do

3 During the past 4 weeks. . .

Have you had any trouble getting in and out of a car or using public transport because of your shoulder?

☐ No trouble at all ☐ A little bit of trouble ☐ Moderate trouble ☐ Extreme difficulty ☐ Impossible to do

4 During the past 4 weeks. . .

Have you been able to use a knife and fork at the same time?

☐ Yes, easily ☐ With little difficulty ☐ With moderate difficulty ☐ With extreme difficulty ☐ No, impossible

5 During the past 4 weeks. . .

Could you do the household shopping on your own if you had to?

☐ Yes, easily ☐ With little difficulty ☐ With moderate difficulty ☐ With extreme difficulty ☐ No, impossible

6 During the past 4 weeks. . .

Could you carry a tray containing a plate of food across the room?

☐ Yes, easily ☐ With little difficulty ☐ With moderate difficulty ☐ With extreme difficulty ☐ No, impossible

7 During the past 4 weeks. . .

Could you brush or comb your hair with the affected arm (even if it's not your dominant arm)?

☐ Yes, easily ☐ With little difficulty ☐ With moderate difficulty ☐ With extreme difficulty ☐ No, impossible

8 During the past 4 weeks. . .

How would you describe the pain you usually had from your shoulder?

☐ None ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe

9 During the past 4 weeks. . .

Could you hang your clothes up in a wardrobe using the affected arm?

☐ Yes, easily ☐ With little difficulty ☐ With moderate difficulty ☐ With extreme difficulty ☐ No, impossible

10 During the past 4 weeks. . .

Have you been able to wash and dry yourself under both arms?

☐ Yes, easily ☐ With little difficulty ☐ With moderate difficulty ☐ With extreme difficulty ☐ No, impossible

11 During the past 4 weeks. . .

How much pain from your shoulder interfered with your usual work (including housework)?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Greatly ☐ Totally

12 During the past 4 weeks. . .

Have you been troubled by pain from your shoulder in bed at night?

☐ No ☐ 1 or 2 nights ☐ Some nights ☐ Most nights ☐ Every night

The American Shoulder & Elbow Society Rating Scale

1 If 0 = no pain and 10 = the worst pain, how bad is your pain **today** out of 10? _____

2 Tick the box beside the number that indicates your ability to do the following activities **normally** (not just today)

Important: **0 = unable to do and 3 = easy to do for the following questions**

	LEFT Shoulder *(we need both for comparison)* **RIGHT Shoulder**							
	Unable ↓	**Very difficult** ↓	A bit difficult ↓	Easy to do ↓	Unable ↓	Very difficult ↓	A bit difficult ↓	Easy to do ↓
Put on a coat	☐ 0	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 2	☐ 3
Sleep on your side	☐ 0	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 2	☐ 3
Wash your back or do your bra up	☐ 0	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 2	☐ 3
Manage toileting	☐ 0	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 2	☐ 3
Comb hair (or if bald/other handed, do that action)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 2	☐ 3
Reach a high shelf	☐ 0	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 2	☐ 3
Lift 5kgs or 10lbs above the shoulder	☐ 0	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 2	☐ 3
Throw a ball overhand	☐ 0	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 2	☐ 3
Do your usual work or activities	☐ 0	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 2	☐ 3
Do your usual sport or hobby/leisure activity	☐ 0	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 2	☐ 3
	↑ Unable	↑ Very difficult	↑ A bit difficult	↑ Easy to do	↑ Unable	↑ Very difficult	↑ A bit difficult	↑ Easy to do

3 Are you having pain in your shoulder? ☐ Yes ☐ No

4 Do you have pain in your shoulder at night? ☐ Yes ☐ No

5 Do you take pain medication (eg Panadol, Nurofen, Aspirin etc?) ☐ Yes ☐ No

6 Do you take narcotic medication (eg Panadeine, Nurofen Plus or stronger?) ☐ Yes ☐ No

7 How many tablets do you take each day (on average) **for your shoulder**? _____ tablets

8 Does your shoulder feel unstable (ie as if it is going to dislocate)? ☐ Yes ☐ No

9 If 0 = not unstable and 10 = unstable, how unstable does your shoulder feel **today** out of 10? _____

Consent to Collect Patient Information – Privacy Act 2002

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

I understand the reasons why my information must be collected.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purpose other than the above, my consent will be sought.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

ADDENDUM

I also understand that I seek the care of Dr Young for my medical management and that it is a policy of the practice that Dr Young does not undertake examinations and/or reports for the purpose of Medico-Legal matters.

Signed: _____ **Today's Date:** _____/_____/_____

Patient Name (please print): _____