<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Family History</th>
<th>Yes</th>
<th>No</th>
<th>Member</th>
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<tr>
<td>CONSTITUTIONAL:</td>
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<td>Recent weight changes</td>
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<tr>
<td>Recent fever, weakness or fatigue</td>
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<tr>
<td>EYES:</td>
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<td>Wear glasses or contact lenses</td>
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<tr>
<td>Glaucoma</td>
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<td>Cataracts</td>
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<td>EARS, NOSE, THROAT:</td>
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<td>Hearing Problems</td>
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<td>Dizziness</td>
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<td>Recent cold or sinus pain</td>
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<tr>
<td>Recent sore throat</td>
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<td>CARDIOVASCULAR:</td>
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<tr>
<td>Chest pain</td>
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<td>Heart attack</td>
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<td>Stroke</td>
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<td>Heart failure</td>
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<td>High blood pressure</td>
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<td>Irregular heartbeat</td>
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<td>Swelling of hands or feet</td>
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<td>Blood clots</td>
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<tr>
<td>High cholesterol</td>
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</table>
DR. BRAND
SHOULDER MEDICAL HISTORY FORM

**RESPIRATORY:**
- **Asthma**
  - [ ] Yes
  - [ ] No
  - Family History
  - [ ] Yes
  - [ ] No
  - Member: ____________________________
- **Emphysema**
  - [ ] Yes
  - [ ] No
  - Family History
  - [ ] Yes
  - [ ] No
  - Member: ____________________________
- **Bronchitis**
  - [ ] Yes
  - [ ] No
  - Family History
  - [ ] Yes
  - [ ] No
  - Member: ____________________________
- **Pneumonia**
  - [ ] Yes
  - [ ] No
  - Family History
  - [ ] Yes
  - [ ] No
  - Member: ____________________________

**GASTROINTESTINAL:**
- **Recent changes in bowel habits**
  - [ ] Yes
  - [ ] No
- **Rectal bleeding**
  - [ ] Yes
  - [ ] No
- **Liver disease**
  - [ ] Yes
  - [ ] No
  - Family History
  - [ ] Yes
  - [ ] No
  - Member: ____________________________

**URINARY:**
- **Problems with urination**
  - [ ] Yes
  - [ ] No
- **Urinary tract infections**
  - [ ] Yes
  - [ ] No
- **Kidney disease**
  - [ ] Yes
  - [ ] No
  - Family History
  - [ ] Yes
  - [ ] No
  - Member: ____________________________

**SKIN:**
- **Recent or current rashes or eruptions**
  - [ ] Yes
  - [ ] No
  - Where: ____________________________

**NEUROLOGICAL:**
- **Seizures**
  - [ ] Yes
  - [ ] No
  - Family History
  - [ ] Yes
  - [ ] No
  - Member: ____________________________
- **Paralysis**
  - [ ] Yes
  - [ ] No
  - Where: ____________________________
- **Numbness or tingling**
  - [ ] Yes
  - [ ] No
  - Where: ____________________________
- **Depression/mental illness**
  - [ ] Yes
  - [ ] No
  - When: ____________________________
- **Anxiety disorders**
  - [ ] Yes
  - [ ] No
  - When: ____________________________

**ENDOCRINE:**
- **Thyroid**
  - [ ] Yes
  - [ ] No
  - Family History
  - [ ] Yes
  - [ ] No
  - Member: ____________________________
- **Diabetes**
  - [ ] Yes
  - [ ] No
  - Family History
  - [ ] Yes
  - [ ] No
  - Member: ____________________________
  - **Treatment:**
    - [ ] Diet
    - [ ] Oral Meds
    - [ ] Insulin
  - **Medical complications:**
    - [ ] Vascular
    - [ ] Renal
    - [ ] Neuropathy
    - [ ] Other: ____________________________

**HEMATOLOGIC/LYMPHATIC:**
- **Anemia**
  - [ ] Yes
  - [ ] No
  - Family History
  - [ ] Yes
  - [ ] No
  - Member: ____________________________
- **Transfusions**
  - [ ] Yes
  - [ ] No
  - Family History
  - [ ] Yes
  - [ ] No
  - Member: ____________________________

**CANCER/TUMOR:**
- **Type:** ____________________________
  - **Location:** ____________________________
  - **Treatment:** ____________________________

**OTHER MEDICAL PROBLEMS:**


**HISTORY OF OPERATIONS:**
- [ ] Yes
  - [ ] No
  - **Type:** ____________________________

**DO YOU HAVE ALLERGIES, SENSITIVITIES OR HAVE YOU AN ADVERSE REACTION TO MEDICATIONS?**
- [ ] Yes
  - [ ] No

Please List: ____________________________
CURRENT MEDICATIONS: ____________________________________________________________

When did you last use aspirin in any form? ____________________________________________________________

PERSONAL HISTORY:
Cigarettes    ☐ Yes  ☐ No  Amount: ____________________________________________________________
Alcohol    ☐ Yes  ☐ No  Amount: ____________________________________________________________

OCCUPATION: ____________________________________________________________

TESTS DONE RELATED TO PRESENT INJURY OR COMPLAINT:
☐ X-rays  ☐ MRI  ☐ CT Scan  ☐ EMG  ☐ Bone Scan  ☐ Bone Density  ☐ Bloodwork
Tests performed at: ____________________________________________________________

PRIOR TREATMENT (Best recollection – Check and explain):
☐ Anti-Inflammatories:
☐ Injections (dates & number):
☐ Chiropractic:
☐ Surgery:

Physical Therapy:
☐ Ultrasound  ☐ Massage  ☐ Strengthening  ☐ ROM Stretching
☐ Cybex Machines  ☐ Cryotherapy  ☐ Cortisone Cream  ☐ Manipulation
☐ Electrical Stimulation

YOUR MEDICAL DOCTOR:
Name: ____________________________________________________________
Address: ____________________________________________________________
Phone: ____________________________________________________________

YOUR REFERRING DOCTOR:
Name: ____________________________________________________________
Address: ____________________________________________________________
Phone: ____________________________________________________________

PATIENT SIGNATURE: ____________________________________________________________

MD SIGNATURE/DATE: ____________________________________________________________
Dr. Brand

Shoulder Physical Exam

To be filled out by the physician

Cervical ROM
- Flexion
- Extension
- Lateral bending
- Lateral rotation

General
- Deformity
- Contusion
- Atrophy

Tenderness
- Anterior
- Posterior
- Lateral

Range of Motion
- Forward elevation
- Internal rotation
- External rotation

Strength
- Supraspinatus
- Deltoid

Instability
- Anterior apprehension
- Posterior apprehension
- Inferior apprehension

Rotator Cuff
- Impingement sign
- Hawkin’s sign
- Yergason test

SLAP
- O’Brien’s test

AC Joint
- Adduction stress test

Seapula
- Scapulothoracic crepitus

Neuro Exam
- C5-T1

Wrist/Elbow