THE SPORTS MEDICINE CENTER AT
DANBURY ORTHOPEDICS
Exceptional Care. Real Results.

DR. HENSHAW
SHOULDER MEDICAL HISTORY FORM

Name: ______________________ Date of Birth: __________ Date: __________

Orthopedic History: ______________________ Reason for Visit: __________

Is this problem a result of: ❑ MVA ❑ Liability ❑ Work Related ❑ Trauma

Date of Injury: ____/____/____ Description of Injury: ______________________

Side: ❑ Right ❑ Left Dominant: ❑ Right-Handed ❑ Left-Handed

History of Present Injury or Complaint: ______________________

How long have you had shoulder pain? ______________________

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

Do you take any medications for your shoulder? ❑ Yes ❑ No

What medications do you take for your shoulder? ______________________

Does your shoulder feel unstable (as if it's going to dislocate)? ❑ Yes ❑ No

Do you have pain with daily activities? ❑ Yes ❑ No

Does it hurt to lift your arm above your head? ❑ Yes ❑ No

Do you have pain while throwing? ❑ Yes ❑ No

Have you ever had an injury to your shoulder? ❑ Yes ❑ No

Do you have any numbness or tingling? ❑ Yes ❑ No Where: ______________________

Do you now have or have you ever had:

CONSTITUTIONAL:

Recent weight changes	❑ Yes	❑ No				
Recent fever, weakness or fatigue	❑ Yes	❑ No				

EYES:

Wear glasses or contact lenses	❑ Yes	❑ No				
Glaucoma	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Cataracts	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:

EARS, NOSE, THROAT:

Hearing Problems	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No
Recent cold or sinus pain	❑ Yes	❑ No
Recent sore throat	❑ Yes	❑ No

CARDIOVASCULAR:

Chest pain	❑ Yes	❑ No				
Heart attack	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Stroke	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Heart failure	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
High blood presure	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Irregular heartbeat	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Swelling of hands or feet	❑ Yes	❑ No				
Blood clots	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
High cholesterol	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:

THE SPORTS MEDICINE CENTER AT
DANBURY ORTHOPEDICS
Exceptional Care. Real Results.

DR. HENSHAW
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: ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: ______

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: ______

THE SPORTS MEDICINE CENTER AT
DANBURY
ORTHOPEDICS
Exceptional Care. Real Results.

DR. HENSHAW
SHOULDER MEDICAL HISTORY FORM

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: ______________________________

THE SPORTS MEDICINE CENTER AT
DANBURY ORTHOPEDICS
Exceptional Care. Real Results.

DR. HENSHAW
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	