Name:
Chart:
Age:
Date:

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DR. CIMINIELLO
SHOULDER MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____ Date: _____

Height: _____" Weight: _____ lbs.

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 HAVE ALLERGIES, SENSITIVITIES OR HAVE YOU AN ADVERSE REACTION TO MEDICATIONS OR LATEX? ❑ Yes ❑ No
Please List: _____

CURRENT MEDICATIONS: _____

OTHER MEDICAL PROBLEMS: _____

HISTORY OF OPERATIONS: ❑ Yes ❑ No
Type: _____

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