Surgical Questionnaire (Shoulder) – Pre-Op

Name: ____________________________________________  Date:  ________________

How would you like to be contacted regarding this study: ___ E-Mail/___ Fax /___ Mail

Please give us your Email or Fax:  _______________________________________________

How much pain did you have today on a scale of 0 (No pain) to 10 (Worst pain ever):
Before surgery  __________

How many pills of narcotics (vicodin, codeine, norco, etc) do you take per day:
Before surgery  __________

Did you have pain that woke you up from sleep or at rest without moving:

<table>
<thead>
<tr>
<th></th>
<th>Night Pain</th>
<th>Rest Pain</th>
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</thead>
<tbody>
<tr>
<td>Before surgery</td>
<td>___ YES / ___ NO</td>
<td>___ YES / ___ NO</td>
</tr>
</tbody>
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For the following questions, please indicate the difficulty of the following activities with a number:

(0 – Unable to do   1 – Very difficult to do   2 – Somewhat difficult to do   3 – Not difficult to do)

Before surgery
Putting on a coat ________  
Sleeping ________  
Washing your body ________  
Wiping your bottom ________  
Combing your hair ________  
Reaching out ________  
Lifting your arm ________  
Throwing a ball ________  
Working ________  
Playing sports ________

PT Evaluation:

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<thead>
<tr>
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<th>ROM</th>
<th>Strength</th>
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<tbody>
<tr>
<td>Forward Elevation:</td>
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<tr>
<td>Abduction:</td>
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<tr>
<td>External Rotation:</td>
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Notes: _______________________________________________________________________________