ORTHOSURGERY
Ιατρείο Ορθοπαιδικών Παθήσεων

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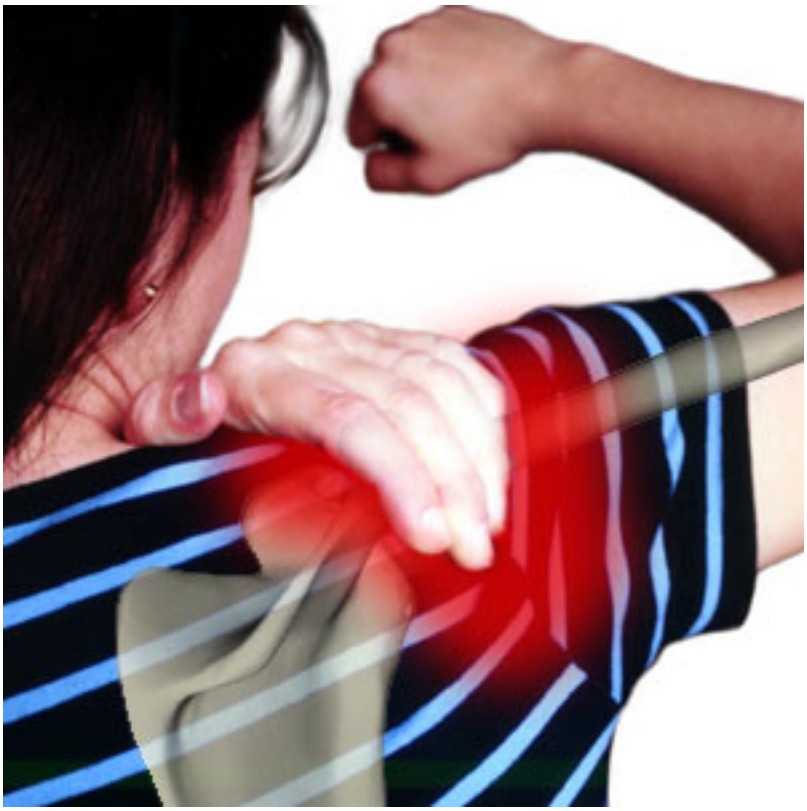
Shoulder Patient Self Evaluation Form



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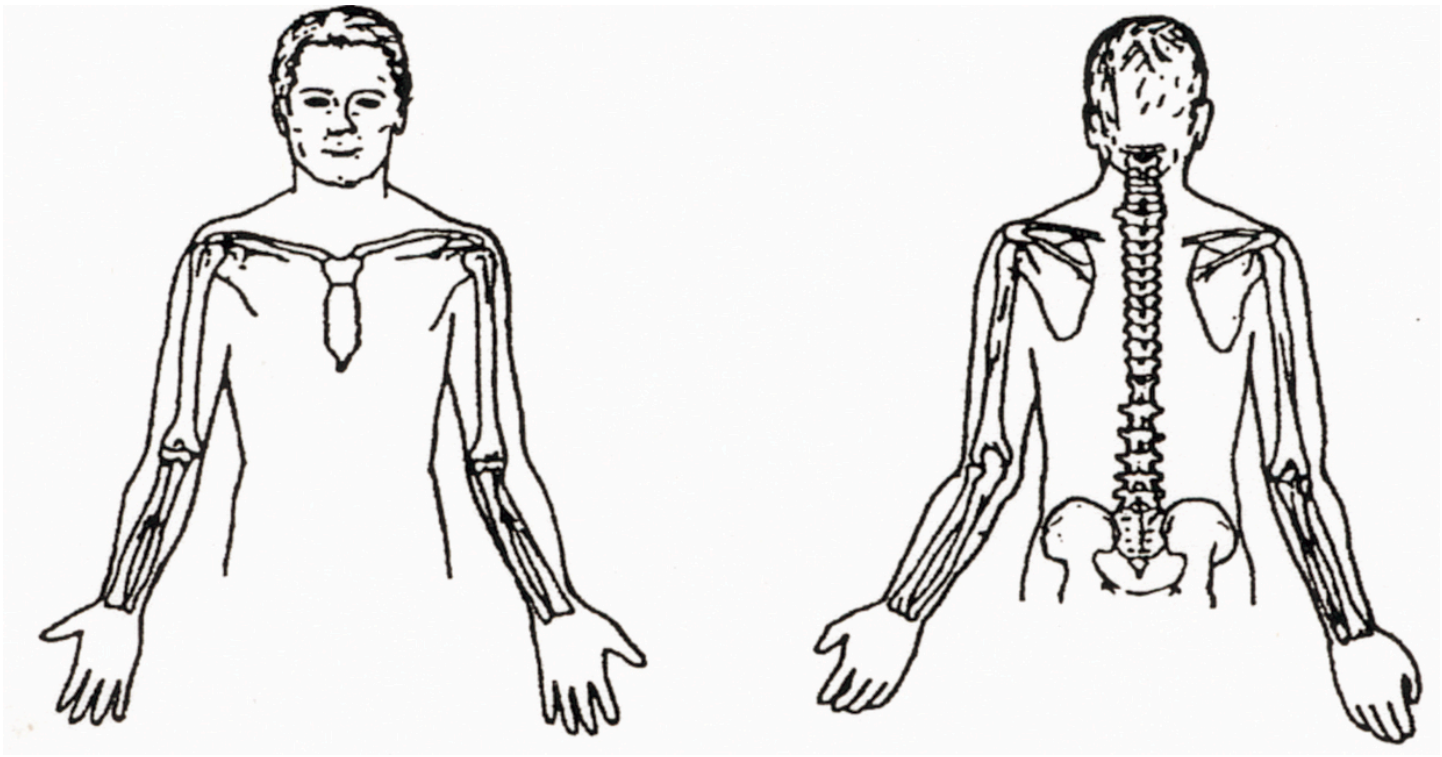

Mark where your pain is on this diagram:

Do you have pain in your shoulder at night?	Yes	No
Do you take pain medication (aspirin, Advil, Tylenol, etc.)?	Yes	No
Do you take narcotic pain medication (codeine or stronger)?	Yes	No
How many pills do you take each day (average)?	_____ pills	
How bad is your pain today? (mark on the scale) 0 1 2 3 4 5 6 7 8 9 10 (No pain at all … Pain as bad as it can be)		
Does your shoulder feel unstable (as if it is going to dislocate)?	Yes	No
How unstable is your shoulder? (mark on the scale) 0 1 2 3 4 5 6 7 8 9 10 (Very stable … Very unstable)		

Circle the number in the box that indicates your ability to do the following activities:

0 = **Unable** to 1 = **Very** difficult 2 = **Somewhat** difficult 4 = **Not** difficult

ACTIVITY		RIGHT ARM	LEFT ARM
1. Put on a coat		0 1 2 3	0 1 2 3
2. Sleep on your painful of affected side		0 1 2 3	0 1 2 3
3. Wash back / do up bra in back		0 1 2 3	0 1 2 3
4. Manage toiletting		0 1 2 3	0 1 2 3
5. Comb hair		0 1 2 3	0 1 2 3
6. Reach a high shelf		0 1 2 3	0 1 2 3
7. Lift 10 lbs. above the shoulder		0 1 2 3	0 1 2 3
8. Throw a ball overhand		0 1 2 3	0 1 2 3
9. Do usual work - List:		0 1 2 3	0 1 2 3
10. Do usual sport - List:		0 1 2 3	0 1 2 3

Name: _____ Date: _____ / _____ / _____