



CONNECTICUT  
CENTER FOR  
ORTHOPEDIC  
SURGERY, LLC

James T. Mazzara, MD

Orthopedic Surgeon

www.OrthoOnTheWeb.com

Name \_\_\_\_\_

Date \_\_\_\_\_

## SHOULDER SURVEY

Dominant hand	Right	Left	Ambidextrous
Shoulder evaluated	Right	Left	Both
Job Injury	Yes	No	
How bad is your pain today?	No pain >	0	1 2 3 4 5 6 7 8 9 10 <Worst pain imaginable
Which word best describes your pain?	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate <input type="checkbox"/> Severe

Select the most accurate statement about your shoulder pain:

- I have no pain
- I have slight pain during activity
- I have increased pain during activities
- I have moderate / severe pain during activities
- I have severe pain and need medication

Select one statement below regarding your shoulder pain.

- Normal function:** I can do all activities of daily living, work and sports activities that I did before my shoulder problem. (Lifting 30 pounds or more, can throw.)
- I have **mild limitations** in sports and work. I can throw but limited, can lift 15-30 pounds, able to wash back, comb hair and get dressed.
- I have **moderate limitations** in overhead work, sports and lifting (10 pounds). I am unable to throw or serve in tennis. Have difficulty with washing back, combing hair or getting dressed (need help sometimes).
- I have **severe limitations**. Cannot do usual work or lifting. No sports. Need help washing and dressing. Can feed myself and comb hair.
- Complete disability** of the arm.

Yes No

- |   |                          |                          |
|---|--------------------------|--------------------------|
| Is your shoulder comfortable with your arm at rest by your side?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your shoulder allow you to sleep comfortably?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you reach the small of your back to tuck in your shirt with your hand?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you place your hand behind your head with the elbow straight out to the side?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you place a coin on a shelf at the level of your shoulder without bending your elbow?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you lift 1 pound (a full pint container) to the level of your shoulder without bending your elbow?    | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you lift 8 pounds (a full gallon container) to the level of your shoulder without bending your elbow? | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you carry 20 pounds at your side with the affected extremity?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you think you can toss a softball under-hand 20 yards with the affected extremity?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you think you can toss a softball over-hand 20 yards with the affected extremity?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you wash the back of your opposite shoulder with the affected extremity?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Would your shoulder allow you to work full-time at your regular job?                                      | <input type="checkbox"/> | <input type="checkbox"/> |

Please rate how your shoulder problem affects your ability to work

Fully able to work> 4 3 2 1 0 <Unable to work

Please rate how your shoulder problem affects your ability to participate in sports and recreational activities

Fully able to participate> 4 3 2 1 0 <Unable to participate

Please note the highest level you can reach to perform *tasks*

Waist level  Chest level  Neck level  Top of head  Overhead

Have you ever dislocated the shoulder?  Yes  No

Is this due to a specific injury?  Yes  No

Is this work related?  Yes  No

Have you had previous x-rays or MRI s of the shoulder?

When \_\_\_\_\_

Where \_\_\_\_\_

Have you had previous treatment for this condition?  Yes  No

When \_\_\_\_\_

Who \_\_\_\_\_

Physical therapy  Medication  Injections  Other

Have you had previous surgery for this condition?

When \_\_\_\_\_

Who \_\_\_\_\_

What kind of surgery \_\_\_\_\_