Bradley S. Schoch, MD

BOARD CERTIFIED ORTHOPEDIC SURGEON

FELLOWSHIP TRAINED IN SHOULDER & ELBOW SURGERY

Patient Information:

Full Name: _____

Date of Birth: ___ / ___ / _____

Phone Number: _____

Email Address: _____

Primary Care Physician: _____

Referring Physician (if applicable): _____

Reason for Visit:

What is the main reason for your visit?

_____

What are your goals for this appointment?

_____

Symptom Description:

When did your symptoms start?

_____

Did they result from an injury? If so, please describe:

_____

Are your symptoms constant, occasional, or activity-related?

_____

Describe the location and nature of your pain:

_____

Pain level (0 = No pain, 10 = Worst pain imaginable): _____

How would you rate the function of the affected joint? (0 = completely disabled, 100% = normal): _____

Have your symptoms improved, worsened, or remained the same over time?

_____

What activities (work, sports, daily tasks) are affected by your condition?

_____

Previous Treatments:

Have you received any of the following treatments?

Medications: _____

Injections (type and date): _____

Physical therapy (duration and type): _____

Previous surgeries (date and details): _____

Medical History:

Do you have any medical conditions (diabetes, high blood pressure, arthritis, etc.)?

Current medications: _____

Medication allergies: _____

Prior Imaging & Records:

Have you had imaging related to this condition (X-rays, MRI, CT scan, etc.)?

_____

If yes, please bring a copy of the report and the actual images on a CD to your appointment.

Additional Notes or Concerns:

_____
