

Holy Cross Medical Group Orthopaedic Institute

Shoulder Patients

We appreciate you taking time to fill out the following information. Your answers will help us to provide you with our best quality care. Feel free to discuss the information with your nurse when you are called back to the examination room.

Some questions allow you to mark ALL appropriate answers, and others ask for the **ONE** best answer. Please pay careful attention to the instructions. We are glad you have chosen us to take care of your orthopaedic needs.

Shoulder Patient History

Medical Record Number: _____

Today's Date: ___ / ___ / ____

First Name _____ Last Name _____ Middle Name _____ Suffix _____

____ / ____ / ____ Date of Birth
____ - ____ - ____ Social Security #
____ Gender
____ Race
____ Marital Status

Location of Problem: Right Shoulder Right Elbow Neck
 Left Shoulder Left Elbow

If more than one, which is the worst?: _____

Date Problem Began (approximate): ____ / ____ / ____

Please describe your current problem:

- New injury or problem (less than 6 weeks duration)
- Subacute problem (6 weeks – 3 months duration)
- Chronic Problem (problem has been treated for more than 3 months and never returned to normal)
- Reinjury (you injured same area before, received treatment, had no problems until this new injury occurred)
-Date of Re-injury ____ / ____ / ____

Is your problem a result of an injury? Yes No

What caused your injury? Fall Fighting
 Lifting Twisting
 Throwing Collision/Contact
 Reaching Other: _____

Check any of the following that happened at the time of your injury:

- Felt pain Heard pop Had swelling Discoloration
- Dislocation Fracture Other: _____

If your problem is the result of an injury, where did it occur? (Check one answer)

- Home Work Motor Vehicle Accident
- Exercise Sporting Competition Other: _____

Have you talked to a lawyer concerning your injury? Yes No

Are you receiving or have you applied for workers compensation concerning your injury? Yes No

Have you received previous treatment for your current problem? Yes No (If yes, please specify)

- Medicine Physical Therapy Chiropractic Alternative
- Surgical (____ Number of surgeries) Injections (____ Number of injections)

Are you having pain today? Yes No

Is your pain today: Occasional Constant

On a scale of 0 – 10, how would you score your pain today?



Check the words that best describe the character of the pain you are having today:

- Aching Nagging Exhausting
- Miserable Unbearable Tender
- Stabbing Shooting Sharp
- Gnawing Penetrating Tiring
- Burning Numb

Does the pain awaken you from sleep? Never Occasionally Frequently

Does the pain keep you from falling asleep? Never Occasionally Frequently

What time of day is your pain worst? Morning Afternoon Evening Night All the time

What makes your pain better:

- Rest Ice Sitting Lying Down Walking
- Medication Heat Standing Nothing in particular Other: _____

What makes your pain worse:

- Rest Ice Sitting Lying Down Walking
- Medication Heat Standing Nothing in particular Other: _____

Pease tell us your height and weight:

Height: ___ feet ___ inches

Weight: _____ pounds

Referring Physician (first and last name): _____

Address: _____

Review of Systems (Check any problems that apply in each category)

General

- recent weight gain
- recent weight loss
- appetite change
- difficulty sleeping None

Cardiovascular

- chest pain
- heart attack
- palpitations (irregular heart beat)
- heart failure
- edema (leg swelling)
- high blood pressure
- leg cramps with walking None

Pulmonary

- shortness of breath
- cough
- sputum
- bronchitis
- asthma
- night sweats None

Endocrine & Metabolic

- sugar diabetes
- goiter
- thyroid problem
- sterility
- cholesterol / lipid problem None

Hematopoietic / Lymphatic

- anemia
- lymph node enlargement
- bleeding problem
- frequent infections None

Musculoskeletal

- joint pain
- joint swelling or warmth
- joint stiffness
- muscle pain
- weakness
- back pain
- joint deformity None

Gastrointestinal

- heartburn / indigestion
- difficulty swallowing
- stomach pains
- ulcers
- nausea / vomiting
- diarrhea
- hemorrhoids
- rectal bleeding
- black bowel movements
- change in bowel habits
- constipation
- frequent laxative use
- jaundice or hepatitis
- liver trouble
- gallbladder problems None

Neurologic

- headaches
- dizziness
- blackouts
- numbness and tingling
- paralysis
- convulsions / seizures
- coordination trouble None

Genitourinary

- burning on urination
- frequency of urination
- difficulty starting urine
- wetting pants or bed
- bloody urine
- sexual difficulties None

Psychiatric

- anxiety
- depression
- been seen by a psychiatrist None

Past Medical History

Please check any of the following conditions you have or have had in the past.

If you are unsure, please ask a staff member to assist you in filling out this form.

You may check more than one condition.

<input type="checkbox"/> I have no medical problems <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis - rheumatoid (verified with blood test) <input type="checkbox"/> Arthritis - osteo, degenerative <input type="checkbox"/> Bowel disease <input type="checkbox"/> Cancer (specify) _____ <input type="checkbox"/> Cardiac Arrhythmia (Abnormal heart rate) <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery Disease (Angina) <input type="checkbox"/> Cerebrovascular Disease (Stroke) <input type="checkbox"/> Diabetes	<input type="checkbox"/> Depression <input type="checkbox"/> Hypertension (High Blood Pressure) <input type="checkbox"/> Hypercholesterolemia (Elevated Cholesterol) <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disorder (Cirrhosis, Hepatitis) <input type="checkbox"/> Lung Disease <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Parkinson's <input type="checkbox"/> Ulcer Disease <input type="checkbox"/> Osteoprosis <input type="checkbox"/> Other (specify all other) _____ _____ _____
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Have you ever had a blood transfusion? Yes No
 Have you ever had a blood clot? Yes No

Past Surgical History

Please check any of the following surgical procedures you have or have had in the past.

I have **never** had surgery.

	<u>Year of Most Recent Surgery</u>	<u>Year of Previous Surgery</u>
<input type="checkbox"/> Appendectomy	_____	_____
<input type="checkbox"/> CABG (Coronary Artery Bypass Grafting)	_____	_____
<input type="checkbox"/> Cholecystectomy (Removal of Gallbladder)	_____	_____
<input type="checkbox"/> Hysterectomy	_____	_____
<input type="checkbox"/> Mastectomy	_____	_____
<input type="checkbox"/> Herniorrhaphy (Hernia Repair)	_____	_____
<input type="checkbox"/> Tonsillectomy	_____	_____
<input type="checkbox"/> Splenectomy (Removal of Spleen)	_____	_____
<input type="checkbox"/> Discectomy - Cervical Spine	_____	_____
<input type="checkbox"/> Discectomy - Lumbar Spine	_____	_____
<input type="checkbox"/> Fusion - Cervical Spine	_____	_____
<input type="checkbox"/> Fusion - Lumbar Spine	_____	_____
<input type="checkbox"/> Fracture Repair – Ankle <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____
<input type="checkbox"/> Fracture Repair – Knee <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____
<input type="checkbox"/> Fracture Repair – Shoulder <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____
<input type="checkbox"/> Hip replacement <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____
<input type="checkbox"/> Arthroscopy – Knee <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____
<input type="checkbox"/> Cartilage surgery/meniscus <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____
<input type="checkbox"/> Ligament reconstruction – ACL <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____
<input type="checkbox"/> Ligament reconstruction – other <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____
<input type="checkbox"/> Knee replacement <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____
<input type="checkbox"/> Arthroscopy – Shoulder <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____
<input type="checkbox"/> Rotator cuff surgery <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____
<input type="checkbox"/> Shoulder replacement <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____
<input type="checkbox"/> Shoulder stabilization <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____
<input type="checkbox"/> Other (List all others) _____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Please check all diseases for which you have a family history:

- Heart Disease
- Stroke
- Rheumatoid Arthritis
- Arthritis - osteo, degenerative
- Osteoporosis
- Cancer - Breast

- Cancer - Prostate
- Cancer - Other
- Diabetes
- Problems with anesthesia

Reviewed and Unremarkable

Social History

Current Employment:

- Full-time Part-time Retired Student Unemployed Disabled

Job Title: _____

Level of Education:

- Grade school High school/equivalent Some college College degree Graduate degree

Alcohol:

- I drink alcohol
- Rarely (less than 1 drink a month)
- Occasionally (1-4 drinks per month)
- socially (1-2 drinks per week)
- frequently (3-5 drinks per week)
- daily (at least one drink a day)
- I do not drink alcohol, but I used to drink
- I never drank alcohol

Tobacco:

- I have never used tobacco
- I currently smoke the following number of packs per day:
 - 1/2 2
 - 1 2 1/2
 - 1 1/2 3
- Years of tobacco use at this pattern: ____ yrs
- I do not use tobacco, but I used to use

Exercise. Do you exercise regularly? Yes No

How often? daily 3 times per week weekly at least once every other week

Allergies Are you allergic to any medications? Yes No. Please list

Current Medications

Please list the medications you are currently taking - Please include prescription and non-prescription medication. Please list doses and number of times taken daily

Please check any **anti-inflammatory medication** listed below which you have taken in the past. Please include all prescription, non-prescription and samples provided.

- Advil
- Arthrotec
- Daypro
- Ibuprofen
- Lodine

- Naprelan
- Naproxen
- Celebrex
- Tylenol
- Ultram

Other (specify) _____

Please check any of the following **side effects** you experienced while taking any of the above **anti-inflammatory medications**.

- Nausea Diarrhea Gastric ulcers Upset stomach Vomiting other _____

Please check any of the following medications you take on a regular basis.

- Aspirin Axid Coumadin Cytotec Heparin Maalox
 Mylanta Prevacid Pepcid Zantac Tagamet Prilosec

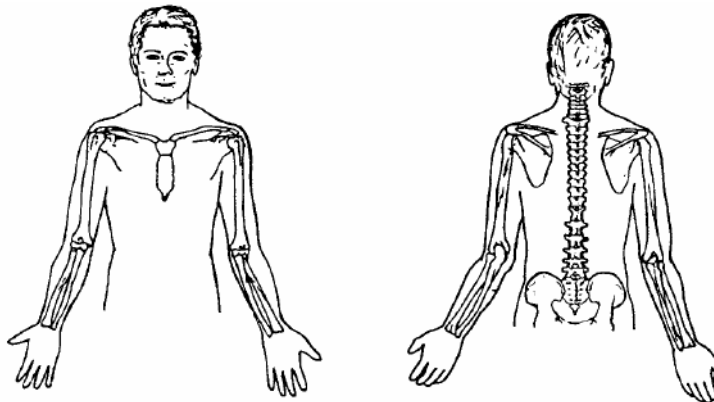
INITIAL SHOULDER QUESTIONNAIRE

TODAY'S DATE: _____

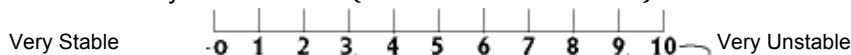
SELF EVALUATION

1. Hand Dominance: Right Left Use both equally
 2. Are you having pain in your shoulder? Yes No

Mark where your pain is on this diagram:



3. Do you have pain in your shoulder at night? Yes No
 4. Do you take pain medication (aspirin, Advil, Tylenol, etc.)? Yes No
 5. Do you take narcotic pain medication (codeine or stronger)? Yes No
 6. Does your shoulder feel unstable (as if it is going to dislocate)? Yes No
 7. How unstable is your shoulder? **(PLEASE MARK A NUMBER)**



8. How would you rate your upper extremity today as a percentage of normal? _____%
 (0% - 100%, with 100% being normal)

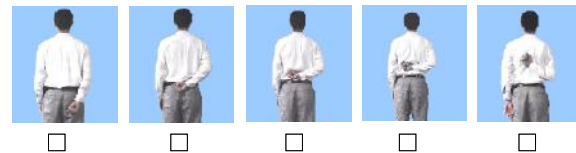
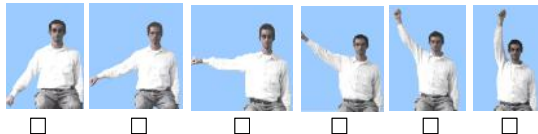
10. Do you have mechanical symptoms (catching, locking or grinding in your joint)? Yes No

RANGE OF MOTION -- Please mark the estimated motion of your shoulder for each of the 3 directions



Forward Flexion – straight in front

Abduction – out to the side



Internal Rotation – reaching up your back

IF YOU HAVE HAD SURGERY, please answer the following questions. Otherwise, please leave them blank.

- a. Does your operated arm feel numb in any region? Yes No
 b. Does your operated arm feel weaker to any activity now than before? Yes No
 c. Does your operated arm feel more painful now than before surgery? Yes No

d. Would you have the same procedure performed upon yourself again? Yes No

e. How would you rate your **personal satisfaction** with your surgery? (**circle one**)

Excellent Good Satisfactory Unsatisfactory

FUNCTION (AMERICAN SHOULDER AND ELBOW SOCIETY SCORE)

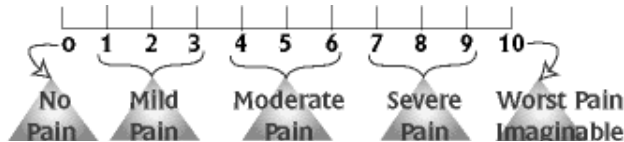
Please note your ability to do the following daily activities, or if you were to try such activities (Best Guess):

0 = **Unable** to do, 1 = **Very difficult** to do, 2 = **Somewhat** difficult, 3 = **Normal** (Check ONLY ONE answer)

	<u>Right Arm</u>	<u>Left Arm</u>
1. Put on a coat	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
2. Sleep on your affected side	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
3. Wash back/connect bra in back	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
4. Manage toileting	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
5. Comb hair	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
6. Reach a high shelf	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
7. Lift 10lbs above shoulder	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
8. Throw a ball overhead	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
9. Do usual work	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
(Please describe usual work): _____		
10. Do usual sport	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
(Please describe usual sport): _____		

PAIN

On the following scale of 0-10, please mark the average amount of pain you experience in your shoulder on a daily basis. (**PLEASE CIRCLE A NUMBER**)

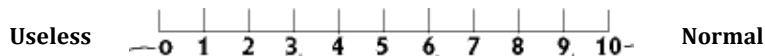


FUNCTION

On the following scale of 0-10, please mark what you consider to be the current overall function of your shoulder.

0 = my shoulder is useless

10 = my shoulder is normal (**PLEASE CIRCLE A NUMBER**)



SIMPLE SHOULDER TEST

Answer each question below by checking "Yes" or "No":

1. Is your shoulder comfortable with your arm at rest by your side? Yes No
2. Does your shoulder allow you to sleep comfortably? Yes No
3. Can you reach the small of your back to tuck in your shirt with your hand? Yes No
4. Can you place your hand behind your head with the elbow straight out to the side? Yes No
5. Can you place a coin on a shelf at the level of your shoulder without bending your elbow? Yes No
6. Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow? Yes No
7. Can you lift eight pounds (a full gallon container) to the level of your shoulder without bending your elbow? Yes No
8. Can you carry twenty pounds at your side with the affected extremity? Yes No
9. Do you think you can toss a softball under-hand 10 yards with the affected extremity? Yes No
10. Do you think you can toss a softball over-hand 20 yards with the affected extremity? Yes No
11. Can you wash the back of your opposite shoulder with the affected extremity? Yes No
12. Would your shoulder allow you to work full-time at your regular job? Yes No

SF-12 - Check ONLY ONE answer for each question

Instructions: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

1. In general, would you say your health is:
- 1 Excellent
 2 Very good
 3 Good
 4 Fair
 5 Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

- | | <u>Yes, Limited
A Lot</u> | <u>Yes, Limited
A Little</u> | <u>No, Not
Limited At
All</u> |
|----------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------|---------------------------------------|
| 2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 3. Climbing several flights of stairs | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like 1-Yes 2-No
5. Were limited in the kind of work or other activities 1-Yes 2-No

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6. Accomplished less than you would like 1-Yes 2-No
7. Didn't do work or perform other activities as carefully as usual 1-Yes 2-No
8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
- 1--Not at all
 2--A little bit
 3--Moderately
 4--Quite a bit
 5--Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks.

- | | <u>All of
the
time</u> | <u>Most of
the
time</u> | <u>A good
bit of the
time</u> | <u>Some
of the
time</u> | <u>A Little
of the
time</u> | <u>None
of the
time</u> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------|---------------------------------------|---------------------------------|-------------------------------------|---------------------------------|
| 9. Have you felt calm and peaceful? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| 10. Did you have a lot of energy? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| 11. Have you felt downhearted and blue? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| 12. During the past 4 weeks, how much of the time has your physical or emotional problems interfered with your social activities (like visiting with friends, relatives, etc)? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |