

Steadman Hawkins Clinic - Denver Elbow/Shoulder

We appreciate you taking time to fill out the following information. Your answers will help us provide you with our best quality care. A computer reads the following forms. Therefore, please follow the instructions carefully. If you feel that you need to provide us with additional information, please **DO NOT** write it on the forms. Instead, feel free to discuss the information with the clinical staff 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.

Review of Systems

Please check all problems you currently experience - **You must check AT LEAST one answer for each category, marking "none of the above" if you experience no problems in that area.**

Overall General Health

- recent weight gain
- recent weight loss
- appetite change
- difficulty sleeping
- none of the above

Endocrine & Metabolic

- sugar diabetes
- goiter
- thyroid problem
- cholesterol / lipid problem
- none of the above

Blood (Hematopoietic / Lymphatic / Immune)

- anemia
- lymph node enlargement
- bleeding problem
- frequent infections
- none of the above

Psychiatric

- anxiety
- depression
- been seen by a psychiatrist
- none of the above

Skin and/or Breast

- rash
- lesions on skin
- lump in breast
- discharge from nipple
- none of the above

Eyes

- change in vision
- red eye
- eye pain
- glaucoma
- none of the above

Ears, Nose, Throat, Mouth (ENT)

- earaches
- nose bleeds
- buzzing in ears
- hoarseness
- hearing loss
- taste change
- sinusitis / nasal stuffiness
- none of the above

RECENT TESTS (within 6 months)

Have you had recent blood tests? No Yes

If yes, give details: _____

Have you had a recent EKG? No Yes

If yes, give details: _____

Have you had a recent Chest X-Ray? No Yes

If yes, give details: _____

Kidney, Bladder, Reproductive (Genitourinary)

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

Are you pregnant? Yes No

(Must answer for X-Ray purposes)?

Lungs (Respiratory / Allergy)

- allergies
- bronchitis
- cough
- shortness of breath
- sputum
- night sweats
- asthma
- none of the above

Heart & Blood Vessels (Cardiovascular)

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

Abdomen (Gastrointestinal)

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

Brain, Nerves, Spinal Cord (Neurologic)

- headaches
- paralysis
- dizziness
- convulsions / seizures
- blackouts
- coordination trouble
- numbness and tingling
- none of the above

Bone & Joint (Musculoskeletal)

- joint pain
- weakness
- joint swelling or warmth
- back pain
- joint stiffness
- joint deformity
- muscle pain
- none of the above

X-Rays/Tests for problem:

Date of test

<input type="checkbox"/> Plain X-Rays	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> MRI	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> CT Scan	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Bone Scan	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Arthrogram	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Other (specify) _____	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>

Did you bring the X-Rays or study with you today? Yes No

IN ORDER TO INSURE PROPER AND COMPREHENSIVE CARE, YOU MUST FOLLOW-UP WITH YOUR PRIMARY CARE PHYSICIAN FOR ANY AND ALL MEDICAL PROBLEMS AND CONCERNS CHECKED HERE.



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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.

Medical Condition History Check this box if you have no medical problems — no medical problems

- Alcoholism, Anemia, Anxiety, Asthma, Arthritis - rheumatoid, Arthritis - osteo, degenerative, Blood Clot, Blood Transfusion, Bowel disease, Cancer, Cardiac Arrhythmia, Congestive Heart Failure, Coronary Artery Disease, Cerebrovascular Disease, COPD, Diabetes, Depression, Fibromyalgia, GERD, Gout, Heart Attack, Hypertension, Hypercholesterolemia, Hypothyroidism, Kidney Disease, Liver Disorder - Cirrhosis, Liver Disorder - Hepatitis, Lung Disease, Osteomyelitis, Parkinson's, Ulcer Disease, Other

Surgery/ Procedures These are non-orthopaedic procedures. Please check any procedures you have had and give the year.

Have you ever had surgery? Yes No Year

Ear, Nose, Throat Surgeries

- Deviated Septum, Sinus Repair, Tonsillectomy, Tracheostomy, Vocal Cord Surgery

Gastrointestinal Surgeries

- Appendectomy, Cholecystectomy, Colon Resection, Exploratory Laparoscopy, Hernia, Liver Resection, Small Bowel Obstruction Repair, Splenectomy

Gynecologic Surgeries

- Hysterectomy, Oophorectomy, Ruptured ectopic, Laparoscopy, C-Section

Urologic Surgeries

- Bladder Suspension, Bladder Removed, Lithotripsy, Prostatectomy, Vasectomy

General Surgeries

- Breast Biopsy, Mastectomy, Thyroid Surgery, Whipple

Heart (Cardiac) Surgeries

- CABG, Valve, Angioplasty, Defibrillator, Pace Maker

Vascular Surgeries

- Bypass Graft - Legs, Vascular Access, AAA, Thoracic Aneurysm

Thoracic Surgeries

- Chest Tube, Pulmonary, Pectus

Neurosurgeries

- Brain Tumor, Brain Aneurysm, Chiari Decompression, Spinal Cord Tumor, Epidural Injection, Abscess, Stent



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Drug Allergy and Medication Information

Have you ever had problems with anesthesia? Yes No *If yes, describe* _____

Are you allergic to latex? Yes No

Are you allergic to any medications? Yes No *If yes, please write the name of the drug in the boxes below and check the reaction you experienced. Please write only one drug in each space provided. If you have more than 3 drug allergies list the others in the space provided.*

Specify Drug:

Describe: shock breathing problems rash nausea other _____

Specify Drug:

Describe: shock breathing problems rash nausea other _____

Specify Drug:

Describe: shock breathing problems rash nausea other _____

Please list additional drug allergies here: _____

Please list the medications you are currently taking - Please include prescription and non-prescription medication

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

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Advil | <input type="checkbox"/> Naprelan |
| <input type="checkbox"/> Arthrotec | <input type="checkbox"/> Naproxen |
| <input type="checkbox"/> Bextra | <input type="checkbox"/> Oruval/Orudis |
| <input type="checkbox"/> Celebrex | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Daypro | <input type="checkbox"/> Ultram |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Vioxx |
| <input type="checkbox"/> Indocin | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Lodine | |

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 Coumadin Heparin Maalox Mylanta Pepcid Prevacid Prilosec Tagamet Zantac

Family Medical History

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer - Breast | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Family health history is unknown |
| <input type="checkbox"/> Cancer - Prostate | <input type="checkbox"/> Arthritis - osteo, degenerative | |
| <input type="checkbox"/> Cancer - Other | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Spine Problems | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Gout | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Lupus | |

If you know your parents' health history please provide the information below. Otherwise, please leave blank.

Father alive deceased *Age (current age or age deceased)* **Health Problems:** cancer rheumatoid arthritis
 heart disease osteoarthritis
 high blood pressure gout
 stroke lupus
 diabetes

Mother alive deceased *Age (current age or age deceased)* **Health Problems:** cancer rheumatoid arthritis
 heart disease osteoarthritis
 high blood pressure gout
 stroke lupus
 diabetes

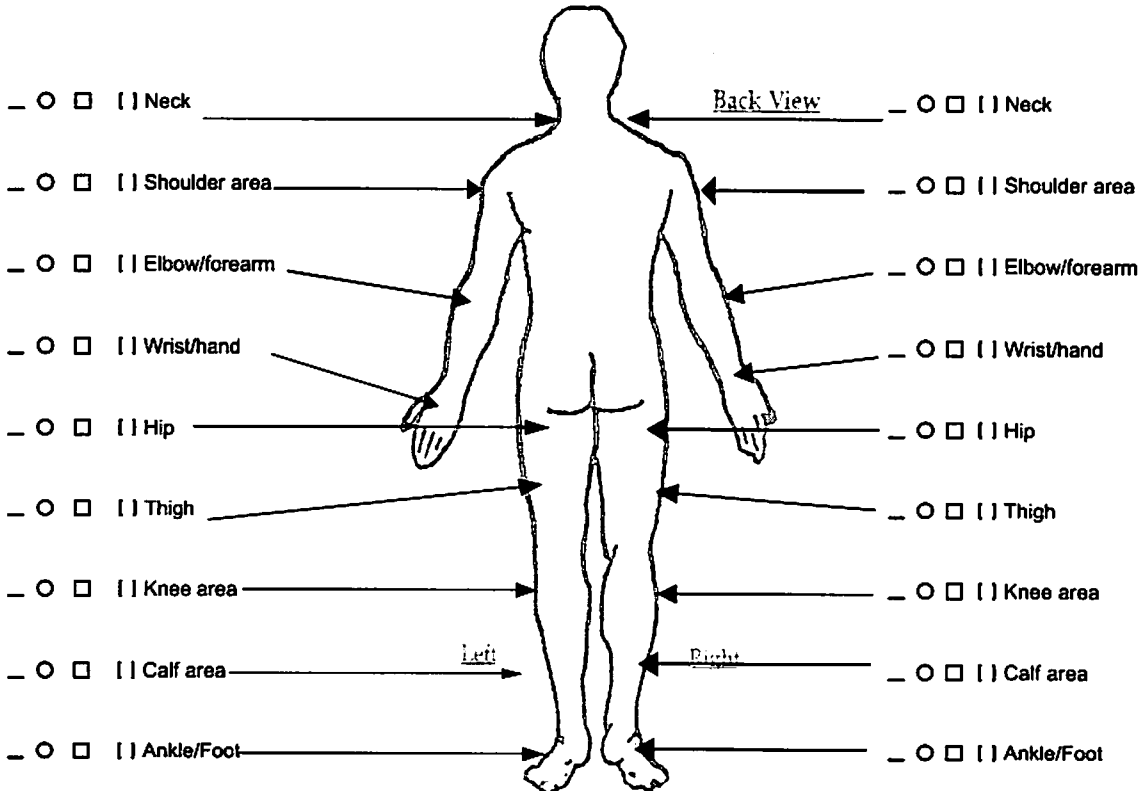
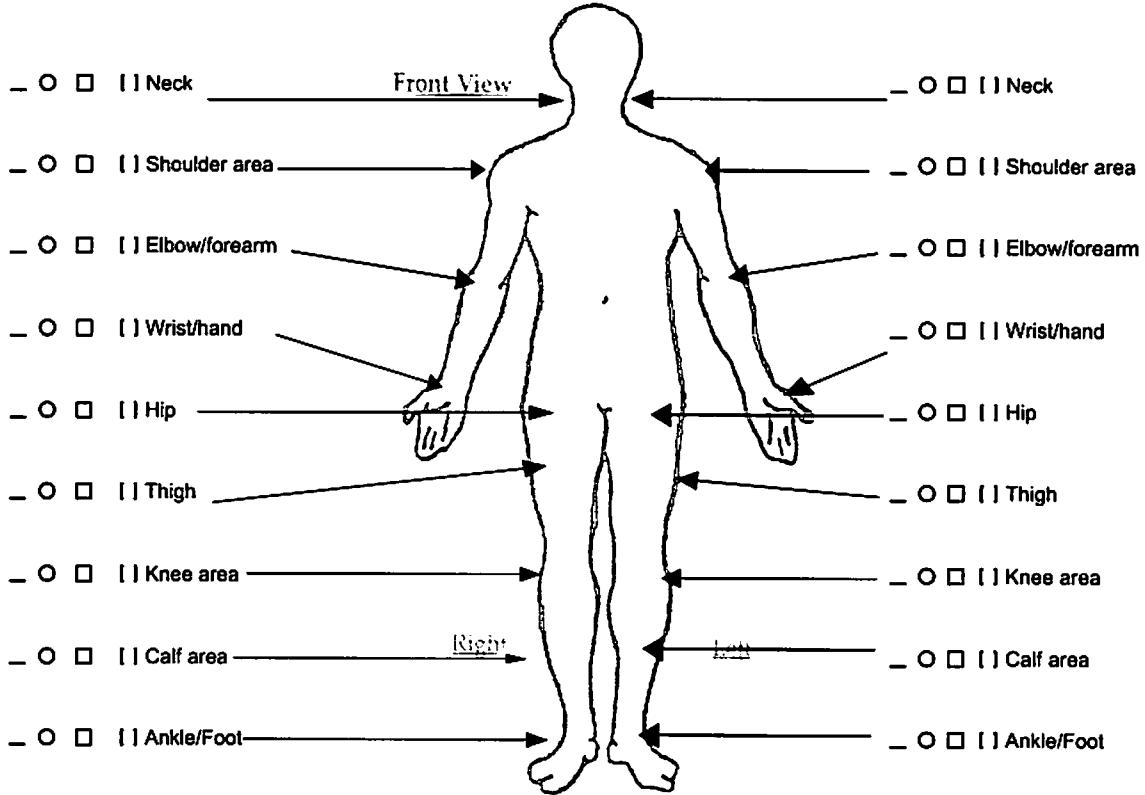


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Hand Dominance: Right Left Use both equally

Please place an X on the areas where you feel the sensations described below. Include all affected areas.

Aching Numbness Pins and Needles () Burning



Current Shoulder or Elbow Function Score

These questions provide us with scores regarding your shoulder or elbow function. By answering these questions you will provide us with a better idea of the current state of your shoulder or elbow condition as well as the outcome of any treatment options.

Check the location of your worst problem and each question below for that area: Elbow Shoulder

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

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

If yes, check all that you experience: catching grinding locking popping

Are you having pain in your shoulder (elbow)? Yes No

Do you have pain in your shoulder (elbow) 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 for your pain (average)?

Does your shoulder (elbow) feel unstable (as it is going to dislocate)? Yes No

How unstable is your shoulder (elbow)? (PLEASE MARK A NUMBER)

0 1 2 3 4 5 6 7 8 9 10
very stable *very unstable*

Please note your ability to do the following daily activities, or if you were to try such activities (Best Guess):
 1 = Unable to do, 2 = Very difficult to do, 3 = Somewhat difficult, 4 = Normal (Check ONLY ONE answer for each arm)

	Right Arm				Left Arm			
1. Do usual work Describe usual work:	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
2. Do usual Describe usual sport:	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
3. Put on coat	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
4. Sleep on Your Side	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
5. Wash Your Back / Fasten	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
6. Manage	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
7. Place Hand Behind Your Head With Elbow Out to	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
8. Place Coin on Shelf at Level of Shoulder Without Bending	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
9. Lift 10 Pounds to the Level of Shoulder Without Bending	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
10. Toss a Softball Overhand 20 Yards	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
11. Do usual daily	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
12. Do usual school	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4

Please note your ability to reach or move your shoulder in any of the following directions:
 1 = Unable to do, 2 = Very difficult to do, 3 = Somewhat difficult, 4 = Normal (Check ONLY ONE answer for each arm)

13. Overhead	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
14. Out to side	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
15. Across your chest	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
16. Behind your back	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
17. Forward	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4

At what level can you use your arm for painless reasonably strong activities?

Overhead Up to top of Head Up to Neck Up to Nipple Line Up to Waist

If you have had surgery, please answer the following questions. Otherwise, please leave them blank.

Does your operated arm feel numb in any region? Yes No

Does your operated arm feel weaker to any activity now than before? Yes No

Does your operated arm feel more painful now than before surgery? Yes No



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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

(#2 and #3) 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="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 3. Climbing several flights of stairs | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

(#4 and #5) 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?

- | | <u>Yes</u> | <u>No</u> |
|---|-------------------------|-------------------------|
| 4. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 5. Were limited in the kind of work or other activities | <input type="radio"/> 1 | <input type="radio"/> 2 |

(#6 and #7) 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)?

- | | <u>Yes</u> | <u>No</u> |
|---|-------------------------|-------------------------|
| 6. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 7. Didn't do work or perform other activities as carefully as usual | <input type="radio"/> 1 | <input type="radio"/> 2 |

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

(#9, #10 and #11) 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
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="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |
| 10. Did you have a lot of energy? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |
| 11. Have you felt downhearted and blue? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 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)?

- | | <u>All
of the
time</u> | <u>Most
of the
time</u> | <u>Some
of the
time</u> | <u>A little
of the
time</u> | <u>None
of the
time</u> |
|--|--------------------------------|---------------------------------|---------------------------------|-------------------------------------|---------------------------------|
| | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |

X _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

X _____
DATE

X _____
DOCTOR'S INITIALS