Holy Cross Medical Group
Orthopaedic Institute

Elbow 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.

Elbow 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 ☐ Left Shoulder ☐ Right Elbow ☐ Left Elbow ☐ Neck

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 ☐ Lifting ☐ Throwing ☐ Reaching ☐ Fighting ☐ Twisting ☐ Collision/Contact ☐ 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.

☐ I have **no** medical problems
☐ Alcoholism
☐ Anemia
☐ Anxiety
☐ Asthma
☐ Arthritis - rheumatoid (verified with blood test)
☐ Arthritis - osteo, degenerative
☐ Bowel disease
☐ Cancer (specify)________________________________
☐ Cardiac Arrhythmia (Abnormal heart rate)
☐ Congestive Heart Failure
☐ Coronary Artery Disease (Angina)
☐ Cerebrovascular Disease (Stroke)
☐ Diabetes
☐ Depression

☐ Hypertension (High Blood Pressure)
☐ Hypercholesterolemia (Elevated Cholesterol)
☐ Hypothyroidism
☐ Kidney Disease
☐ Liver Disorder (Cirrhosis, Hepatitis)
☐ Lung Disease
☐ Osteomyelitis
☐ Parkinson's
☐ Ulcer Disease
☐ **Osteoprosis**
☐ Other (specify all other)______________________________
____
____

Have you ever had a blood transfuion? ☐ 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.

Procedure	Side	Year of Most Recent Surgery	Year of Previous Surgery
☐ Appendectomy		______	______
☐ CABG (Coronary Artery Bypass Grafting)		______	______
☐ Cholecystectomy (Removal of Gallbladder)		______	______
☐ Hysterectomy		______	______
☐ Mastectomy		______	______
☐ Herniorrhaphy (Hernia Repair)		______	______
☐ Tonsillectomy		______	______
☐ Splenectomy (Removal of Spleen)		______	______
☐ Discectomy - Cervical Spine		______	______
☐ Discectomy - Lumbar Spine		______	______
☐ Fusion - Cervical Spine		______	______
☐ Fusion - Lumbar Spine		______	______
☐ Fracture Repair – Ankle	☐ Right ☐ Left ☐ Both	______	______
☐ Fracture Repair – Knee	☐ Right ☐ Left ☐ Both	______	______
☐ Fracture Repair – Shoulder	☐ Right ☐ Left ☐ Both	______	______
☐ Hip replacement	☐ Right ☐ Left ☐ Both	______	______
☐ Arthroscopy – Knee	☐ Right ☐ Left ☐ Both	______	______
☐ Cartilage surgery/meniscus	☐ Right ☐ Left ☐ Both	______	______
☐ Ligament reconstruction – ACL	☐ Right ☐ Left ☐ Both	______	______
☐ Ligament reconstruction – other	☐ Right ☐ Left ☐ Both	______	______
☐ Knee replacement	☐ Right ☐ Left ☐ Both	______	______
☐ Arthroscopy – Shoulder	☐ Right ☐ Left ☐ Both	______	______
☐ Rotator cuff surgery	☐ Right ☐ Left ☐ Both	______	______
☐ Shoulder replacement	☐ Right ☐ Left ☐ Both	______	______
☐ Shoulder stabilization	☐ Right ☐ Left ☐ Both	______	______

☐ 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:

☐ ½ ☐ 2
☐ 1 ☐ 2½
☐ 1½ ☐ 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 ELBOW QUESTIONNAIRE

PATIENT NAME: ______________________ **TODAY'S DATE:** ____________________

SELF EVALUATION

1. Hand Dominance: ☐Right ☐Left ☐Use both equally
2. Are you having pain in your elbow? ☐Yes ☐No
3. Do you take pain medication (aspirin, Advil, Tylenol, etc.)? ☐Yes ☐No
4. Do you take narcotic pain medication (codeine or stronger)? ☐Yes ☐No
5. Does your elbow feel unstable (as if it is going to dislocate)? ☐Yes ☐No
6. How would you rate your upper extremity today as a percentage of normal? ______%
7. Do you have mechanical symptoms (catching, locking or grinding in your joint)? ☐Yes ☐No

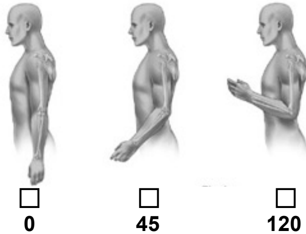
Mayo Elbow Performance Score

1. Are you able to comb hair? ☐Yes ☐No
2. Are you able to feed yourself? ☐Yes ☐No
3. Are you able to perform personal hygiene tasks (ie, wiping)? ☐Yes ☐No
4. Are you able to put on a shirt? ☐Yes ☐No
5. Are you able to put on shoes? ☐Yes ☐No

RANGE OF MOTION

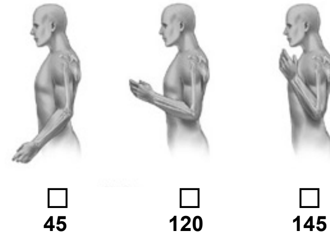
Please mark the estimated motion of your elbow. (Mark one box for start and one box for finish)

How well can you **STRAIGHTEN:**



☐ **0** ☐ **45** ☐ **120**

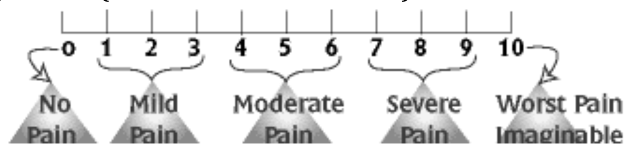
How well can you **BEND:**



☐ **45** ☐ **120** ☐ **145**

VAS PAIN

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

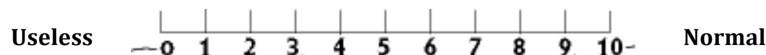


VAS FUNCTION

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

0 = my elbow is useless
10 = my elbow is normal **(PLEASE CIRCLE A NUMBER)**

Useless



Normal

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)

	Right Arm	**Left Arm**
1. Put on a coat	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
2. Sleep on your affected side	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
3. Wash back/connect bra in back	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
4. Manage toileting	☐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 10lbs above shoulder	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
8. Throw a ball overhead	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
9. Do usual work	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3

(Please describe usual work): ______________________________

10. Do usual sport	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3

(Please describe usual sport): ______________________________

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

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?

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐ 1	☐ 2	☐ 3
3. Climbing several flights of stairs	☐ 1	☐ 2	☐ 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.

	All of the time	Most of the time	A good bit of the time	Some of the time	A Little of the time	None of the time
9. Have you felt calm and peaceful?	☐1	☐2	☐3	☐4	☐5	☐6
10. Did you have a lot of energy?	☐1	☐2	☐3	☐4	☐5	☐6
11. Have you felt downhearted and blue?	☐1	☐2	☐3	☐4	☐5	☐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)?	☐1	☐2	☐3	☐4	☐5	☐6