

New Shoulder & Elbow Patient Form

UW Medicine

Bone and Joint Center – Shoulder & Elbow Team
4245 Roosevelt Way NE Seattle, WA 98105-6920 Campus Box 354740

Affix Pt Label Here

Name: _____
U Number: _____
DOB: _____

Name _____ Date _____ Age _____

How did you hear about us? _____

Requesting Physician

Name _____ UPIN # _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____ email _____

Primary Care Physician

Name _____ UPIN # _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____ email _____

Chief Complaint - Please describe the problem that brings you into the office today:

Social History

Tobacco Use

Mark Only One:

Never

Quit

Passive

Yes

Packs per day:

0.5

1

1.5

2

Years:

5

10

15

20

Date quit: _____

Types:

Cigarettes

Pipe

Cigars

Snuff

Chew

Alcohol Use

No

Drinks per week:

Yes # _____ Can(s) of beer

_____ Drink(s) containing 0.5 oz of alcohol

_____ Glass(es) of wine

_____ Shot(s) of liquor

Drug use

No

Use per week:

Yes

1

2

5

10

IV drug use:

No

Yes

Are you currently working? Yes No What is or was your occupation? _____

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Family History

Please check if any of your **family members** have had the following:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Colorectal cancer | <input type="checkbox"/> Lipids |
| <input type="checkbox"/> Alcohol/Drug | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Allergic/Atopic Disease | <input type="checkbox"/> Gastrointestinal (GI) | <input type="checkbox"/> Psych |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Genitourinary (GU) | <input type="checkbox"/> Pulmonary |
| <input type="checkbox"/> Autoimmune | <input type="checkbox"/> Heart | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid |

Other _____

Past Medical History

1. Do you have, or are you being treated for, any of the following (please check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Allergic rhinitis (477.9) | <input type="checkbox"/> Heart attack (MI) (410.9) |
| <input type="checkbox"/> Anxiety (308.0) | <input type="checkbox"/> Hepatitis ____ (please specify type(s)) (573.3) |
| <input type="checkbox"/> Asthma (493.90) | <input type="checkbox"/> High blood pressure (HTN) (401.9) |
| <input type="checkbox"/> Bipolar (296.8) | <input type="checkbox"/> High cholesterol (272.4) |
| <input type="checkbox"/> Bleeding/clotting disorder (286.9) | <input type="checkbox"/> Psoriasis (696.5) |
| <input type="checkbox"/> Cancer (CA) (234.9) | <input type="checkbox"/> Rheumatoid Arthritis (RA) (714.0) |
| <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Drug (304.90) | <input type="checkbox"/> Stroke (434.91) |
| <input type="checkbox"/> Alcohol (303.9) | <input type="checkbox"/> Transient ischemic attack (TIA) (435.9) |
| <input type="checkbox"/> Chronic lung disease/emphysema (COPD) (496) | <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Hypothyroidism (244.9) |
| <input type="checkbox"/> Congestive heart failure (CHF) (428.0) | <input type="checkbox"/> Hyperthyroidism (242.90) |
| <input type="checkbox"/> Coronary artery disease (CAD) (414.00) | <input type="checkbox"/> Sleep Apnea (780.57) |
| <input type="checkbox"/> Depression (311) | <input type="checkbox"/> Other Sleep disorder/trouble sleeping/(insomnia) (780.50) |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Using insulin (IDDM) (250.01) | <input type="checkbox"/> Ulcers <input type="checkbox"/> Stomach ulcers (531) |
| <input type="checkbox"/> Not using insulin (NIDDM) (250.00) | <input type="checkbox"/> Peptic ulcer disease (PUD) (533) |
| <input type="checkbox"/> Fibromyalgia (729.1) | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Heartburn (787.1) | _____ |
| <input type="checkbox"/> Reflux (GERD) (530.81) | _____ |
| | <input type="checkbox"/> NO PAST MEDICAL HISTORY (1000) |

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Past Surgical History

1. What studies have you had for this problem? (Check all that apply)

X-rays CT MRI Arthrogram Nerve Study (EMG) Bone Scan

Other: _____

2. Have you had any previous surgeries for this problem? Yes No

Surgeries for This Problem and if they helped	Surgeon	Year

3. List all Other Bone/Joint (Orthopedic) Surgeries.

Surgeries	Year

4. Please list/check all Other Surgeries you have had.

Surgeries	Year
<input type="checkbox"/> No previous surgeries (100)	_____
<input type="checkbox"/> Appendix (appendectomy) (44950)	_____
<input type="checkbox"/> Gall bladder (cholecystectomy) (47600)	_____
<input type="checkbox"/> Bypass/open heart (CABG) (33999)	_____
<input type="checkbox"/> Hernia Repair (49585)	_____
<input type="checkbox"/> Hysterectomy (581550)	_____
<input type="checkbox"/> Tonsils removed (tonsillectomy) (42820)	_____

Other Surgeries	Year

Musculoskeletal	20999	Neck/Chest	21899
Arthroscopy	29909	Spine	22899
Shoulder	23929	Pelvis/Hip	27299
Upper Arm/Elbow	24999	Femur/Knee	27599
Forearm/Wrist	25999	Leg/Ankle	27899
Hand/Finger	26989	Foot/Toes	28899

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Allergies

1. Do you have any allergies? Yes No if so, please list

To Medications? _____

To Foods? _____

2. Are you allergic to latex? Yes No

3. Are you allergic to iodine? Yes No

Medications

1. Are you taking any pain medications YES NO If so, please list all:

Pain Medications	Dose	Times per day	Reason for taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. All other Medications	Dose	Times per day	Reason for taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Please Check one: Right Handed Left Handed Ambidextrous

Is this a work related problem? Yes No

If yes, list your OWCP Claim# _____ or L&I Claim# _____

If disabled, when did you last work? _____

Is a lawyer involved with this problem? If so, name/address _____

History of Present Illness

1. **Location** - where is the problem located?

Right Side

Shoulder

Left Side

Elbow

Both Sides

Other _____

2. **Severity** - Please rate the intensity of your joint Pain/discomfort: (1 = No Pain, 10 = Severe Pain)

1 2 3 4 5 6 7 8 9 10

3. **Context** - How did this problem begin? _____

4. **Modifying Factors** -

What makes your symptom(s) worse?

Using affected side

Work

Exercise

Don't know

What improves your symptom(s)?

Rest _____

Ice

Heat

Exercise

NSAIDs (anti-inflammatories)

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Review of Systems		
Do you have or had any of the following Problems?		
(Check any that apply)		Comments
General	<input type="checkbox"/> weight gain <input type="checkbox"/> weight gain loss <input type="checkbox"/> fatigue	<input type="checkbox"/> insomnia <input type="checkbox"/> fever <input type="checkbox"/> night-sweats/chills
Eye	<input type="checkbox"/> glasses/contacts <input type="checkbox"/> cataracts	<input type="checkbox"/> glaucoma
Ear/Nose/Throat	<input type="checkbox"/> sinus trouble <input type="checkbox"/> hearing loss	<input type="checkbox"/> ringing in ears
Heart	<input type="checkbox"/> irregular heartbeat <input type="checkbox"/> high blood pressure <input type="checkbox"/> chest pain	<input type="checkbox"/> fluttering in chest <input type="checkbox"/> coronary disease
Lung	<input type="checkbox"/> shortness of breath <input type="checkbox"/> difficulty breathing	<input type="checkbox"/> lung disease <input type="checkbox"/> persistent cough
Stomach	<input type="checkbox"/> decreased appetite <input type="checkbox"/> constipation <input type="checkbox"/> heartburn	<input type="checkbox"/> nausea <input type="checkbox"/> diarrhea <input type="checkbox"/> hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
Muscles/ Bones	<input type="checkbox"/> arthritis <input type="checkbox"/> fractures	<input type="checkbox"/> sprains
Urinary Tract	<input type="checkbox"/> kidney stone <input type="checkbox"/> bladder/kidney infections	<input type="checkbox"/> prostate problems <input type="checkbox"/> painful urinating
Skin	<input type="checkbox"/> masses <input type="checkbox"/> blisters	<input type="checkbox"/> non-healing wounds <input type="checkbox"/> dermatitis
Neurology	<input type="checkbox"/> seizures <input type="checkbox"/> tingling	<input type="checkbox"/> numbness <input type="checkbox"/> severe headaches
Mental Health	<input type="checkbox"/> anxiety <input type="checkbox"/> depression	<input type="checkbox"/> other (please describe)
Endocrine	<input type="checkbox"/> increased thirst <input type="checkbox"/> diabetes	<input type="checkbox"/> thyroid
Blood/Lymph	<input type="checkbox"/> bleeding or clotting problems <input type="checkbox"/> anemia <input type="checkbox"/> swollen or enlarged lymph nodes	
Immunological	<input type="checkbox"/> hay fever <input type="checkbox"/> lupus	<input type="checkbox"/> HIV/AIDS

SANE Score
How would you rate your affected and opposite extremity today as a percentage of normal (0% to 100% scale with 100% being normal)?
Right Side: _____% Left Side: _____%

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Physician Signature _____ Date _____

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**If you have a shoulder problem,
please fill out this Simple Shoulder Test
for BOTH of your shoulders.**

Simple Shoulder Test

Please answer YES or NO for **BOTH** of your shoulders

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

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**If you have an elbow problem,
 please fill out this Elbow Shoulder Test
 for BOTH of your elbows.**

Simple Elbow Test

Please answer YES or NO for **BOTH** of your elbows

		RIGHT		LEFT		
		YES	NO	YES	NO	
1	Is your elbow comfortable with your arm at rest by your side?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
2	Does your elbow allow you to sleep comfortably?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
3	Does your elbow allow you to reach the small of your back to tuck your shirt in?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3
4	Can you place your hand behind your head with the elbow straight out to the side?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4
5	Will your elbow allow you to pull on socks or stockings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5
6	Does your elbow allow you to lift one pound to the level of your shoulder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6
7	Can you use your arm to help you rise from a chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7
8	Will your elbow allow you to carry 20 pounds at your side?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8
9	Will your elbow allow you to comb your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9
10	Will your elbow allow you to throw a ball with this arm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
11	Will your elbow allow you to wash the back of your opposite shoulder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11
12	Would your elbow allow you to work full-time at your regular job?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12

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