

**Return Shoulder and Elbow Form**

**UW Medicine**

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

Affix Pt Label Here

Name:  
U Number:  
DOB:  
DOS:

Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_

**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:	Packs per day:	Years:	Date quit:	Types:
<input type="checkbox"/> Never	<input type="checkbox"/> 0.5	<input type="checkbox"/> 5	_____	<input type="checkbox"/> Cigarettes
<input type="checkbox"/> Quit	<input type="checkbox"/> 1	<input type="checkbox"/> 10		<input type="checkbox"/> Pipe
<input type="checkbox"/> Passive	<input type="checkbox"/> 1.5	<input type="checkbox"/> 15		<input type="checkbox"/> Cigars
<input type="checkbox"/> Yes	<input type="checkbox"/> 2	<input type="checkbox"/> 20		<input type="checkbox"/> Snuff
	<input type="checkbox"/> _____	<input type="checkbox"/> _____		<input type="checkbox"/> Chew

**Medications**

Please all list Pain Medications used	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 a work related problem please list your OWCP Claim# \_\_\_\_\_ or L&I Claim# \_\_\_\_\_

## History of Present Illness

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

- |                                     |                                      |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Right Side | <input type="checkbox"/> Shoulder    |
| <input type="checkbox"/> Left Side  | <input type="checkbox"/> Elbow       |
| <input type="checkbox"/> Both Sides | <input type="checkbox"/> 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)

## Review of Systems

1. Are you having any:  Fevers  Chills  Nausea  Vomiting

2. Do you have any Heart Conditions:  YES  NO Specify: \_\_\_\_\_

3. Do you have any Breathing Problems:  YES  NO Specify \_\_\_\_\_

4. Do you have Diabetes:  YES  NO Specify \_\_\_\_\_

## 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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**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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