New Shoulder Patient 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 _____

Please Check one: ☐Right Handed ☐Left Handed ☐Ambidextrous

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 _____

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 _____

_____

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

_____

History of Present Illness

1. Where is the problem located? ☐Right ☐Left ☐Both / ☐Shoulder ☐Elbow (please be specific)

_____

2. When and How did this problem begin?(date of injury) _____

_____

3. Circle the **symptoms** that best describe your problem:

Stiffness Pain Instability Weakness Roughness Other _____

4. If you have pain, please circle the description(s) that are most appropriate:

Sharp Throbbing Aching Burning Stabbing Heavy Dull

5. 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

6. Is your pain getting: ☐Better gradually ☐Better rapidly ☐Worse ☐Worse gradually ☐Worse rapidly

7. What improves your symptom(s)? _____

8. What makes your symptom(s) worse? _____

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Past Medical History

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

☐ Allergies (allergic rhinitis)	☐ Heart attack (MI)
☐ Anxiety	☐ Hepatitis ____ (please specify type(s))
☐ Asthma	☐ High blood pressure (HTN)
☐ Bipolar	☐ High cholesterol
☐ Bleeding/clotting disorder	☐ Psoriasis
☐ Cancer (CA)	☐ Rheumatoid Arthritis (RA)
☐ Chemical/Alcohol dependency	☐ Stomach ulcers/peptic ulcer disease (PUD)
☐ Chronic lung disease/emphysema (COPD)	☐ Stroke/transient ischemic attack (TIA)
☐ Congestive heart failure (CHF)	☐ Thyroid disorder (please list)_____
☐ Coronary artery disease (CAD)	☐ Sleep Apnea
☐ Depression	☐ Other Sleep disorder/trouble sleeping/(insomnia)
☐ Diabetes (using insulin)(IDDM)	☐ Other (specify)_____
☐ Diabetes (no insulin)(NIDDM)	_____
☐ Fibromyalgia	_____
☐ Heartburn/reflux (GERD)	_____

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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Past Surgical History

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

☐ X-rays ☐ CT ☐ MRI ☐ Nerve Study (EMG) ☐ Arthrogram ☐ 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**
☐ **No previous surgeries**	
☐ Appendix (appendectomy)	
☐ Gall bladder (cholecystectomy)	
☐ Bypass/open heart (CABG)	
☐ Hernia Repair	
☐ Hysterectomy	
☐ Tonsils removed (tonsillectomy)	

Other Surgeries	**Year**

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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

Review of Symptoms
Do you have or had any of the following Problems?

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

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Family History

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

☐ Anesthesia/anesthetics problems	☐ Depression	☐ High Blood Pressure
☐ Arthritis	☐ Diabetes	☐ Kidney disorder
☐ Cancer	☐ Gout	☐ Rheumatoid
☐ Clotting Disorder	☐ Heart Attack	☐ Stroke

Other _____

_____

Social History

1. Are you currently working? ☐Yes ☐No What is or was your occupation? _____
2. Are you married? ☐Yes ☐No Other Relationship: _____
3. Do you have any children? ☐Yes ☐No #____
4. How many individuals live with you now? _____
5. Do you smoke or use tobacco? ☐Yes ☐No How many packs or cans per week? _____
6. Do you consume alcohol? ☐Yes ☐No How many drinks per week? _____
7. Do you currently or have you ever had a problem with drug or alcohol abuse? ☐Yes ☐No (If yes, explain below)

Other Information

Is there anything else we should be aware of or you would like to tell us?

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Physician Signature_____ Date_____

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Simple Shoulder Test

Dominant Hand (*fill in only one circles*): Right ○ Left ○ Ambidextrous ○

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?	○	○	○	○	1
2	Does your shoulder allow you to sleep comfortably?	○	○	○	○	2
3	Can you reach the small of your back to tuck in your shirt with your hand?	○	○	○	○	3
4	Can you place your hand behind your head with the elbow straight out to the side?	○	○	○	○	4
5	Can you place a coin on a shelf at the level of your shoulder without bending your elbow?	○	○	○	○	5
6	Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?	○	○	○	○	6
7	Can you lift eight pounds (a full gallon container) to the level of your shoulder without bending your elbow?	○	○	○	○	7
8	Can you carry twenty pounds at your side with this extremity?	○	○	○	○	8
9	Do you think you can toss a softball under-hand twenty yards with this extremity?	○	○	○	○	9
10	Do you think you can toss a softball over-hand twenty yards with this extremity?	○	○	○	○	10
11	Can you wash the back of your opposite shoulder with this extremity?	○	○	○	○	11
12	Would your shoulder allow you to work full-time at your regular job?	○	○	○	○	12

Office Use Only – For Physician to Fill Out

	DJD	SDJD	RA	FS	PTSS	AVN	CA	CTA	SA	PTCL	RCT	TUBS	AMBRII
R	○	○	○	○	○	○	○	○	○	○	○	○	○
	Other:												
	DJD	SDJD	RA	FS	PTSS	AVN	CA	CTA	SA	PTCL	RCT	TUBS	AMBRII
L	○	○	○	○	○	○	○	○	○	○	○	○	○
	Other:												

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Simple Elbow Test

Dominant Hand (*fill in only one circles*): Right ○ Left ○ Ambidextrous ○

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?	○	○	○	○	1
2	Does your elbow allow you to sleep comfortably?	○	○	○	○	2
3	Does your elbow allow you to reach the small of your back to tuck your shirt in?	○	○	○	○	3
4	Can you place your hand behind your head with the elbow straight out to the side?	○	○	○	○	4
5	Will your elbow allow you to pull on socks or stockings?	○	○	○	○	5
6	Does your elbow allow you to lift one pound to the level of your shoulder?	○	○	○	○	6
7	Can you use your arm to help you rise from a chair?	○	○	○	○	7
8	Will your elbow allow you to carry 20 pounds at your side?	○	○	○	○	8
9	Will your elbow allow you to comb your hair?	○	○	○	○	9
10	Will your elbow allow you to throw a ball with this arm?	○	○	○	○	10
11	Will your elbow allow you to wash the back of your opposite shoulder?	○	○	○	○	11
12	Would your elbow allow you to work full-time at your regular job?	○	○	○	○	12

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	Cont	INST	FInR	TeEl	DiBi	LoBo	TraA	RheA	FArh	UlnN
R	○	○	○	○	○	○	○	○	○	○
	Other:									
	Cont	INST	FInR	TeEl	DiBi	LoBo	TraA	RheA	FArh	UlnN
L	○	○	○	○	○	○	○	○	○	○
	Other:									