

## SHOULDER: NEW PATIENT FORM

\_\_\_\_\_  
PATIENTS NAME

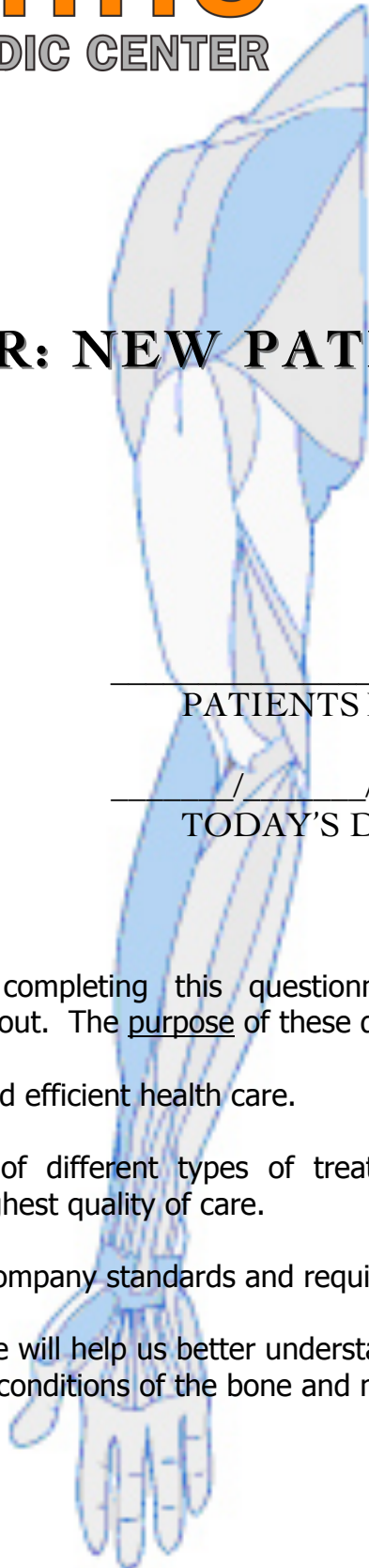
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
TODAY'S DATE

Thank you in advance for completing this questionnaire. This should take approximately 40 minutes to fill out. The purpose of these questions is to:

1. provide more effective and efficient health care.
2. evaluate the outcomes of different types of treatment and therefore allow doctors to provide the highest quality of care.
3. Comply with Insurance Company standards and requirements.

The information that you provide will help us better understand your general health and specific problems related to the conditions of the bone and muscle.

This is a confidential document.



**HOW DID YOU HEAR ABOUT Matthys Orthopaedic Center (M.O.C.)?**

- Newspaper
- Internet
- Billboard
- Phone Book/Yellow pages
- Mailer
- Another patient
- I am already a patient of Dr. Matthys'
- Another Doctor referred me
- Other: \_\_\_\_\_

**NAME OF REFERRING DOCTOR**

**City and State of Referring Doctor**

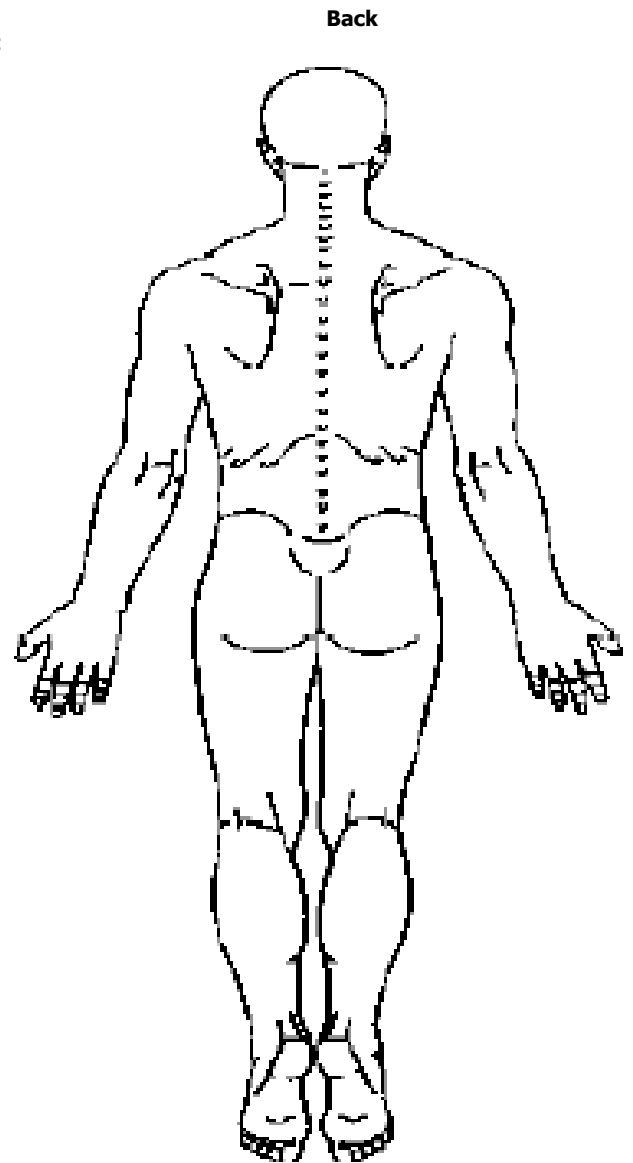
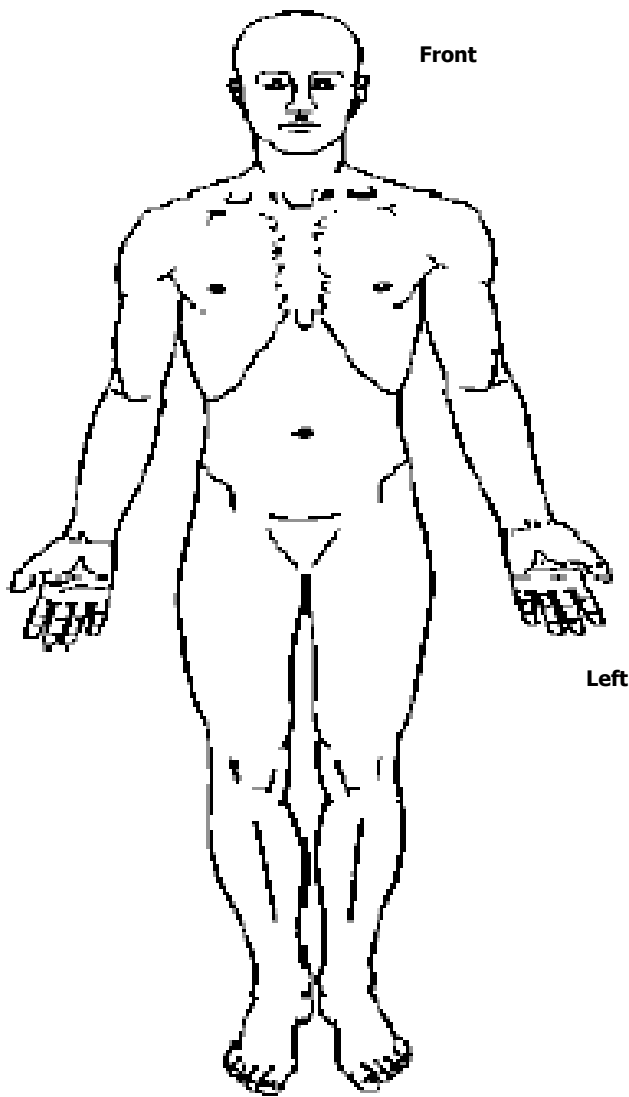
**NAME OF FAMILY DOCTOR (if different)**

**City and State of Family Doctor**

<b>TODAY'S DATE</b> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>	<b>CURRENT EMPLOYMENT STATUS:</b> <input type="checkbox"/> Full time, secretarial or administrative type work <input type="checkbox"/> Full time, with minimal lifting/bending and climbing/walking (eg. Truck driver) <input type="checkbox"/> Full time, with frequent lifting/bending and climbing/walking (eg. Carpenter) <input type="checkbox"/> I am on modified duty because of today's problem <input type="checkbox"/> I am on modified duty because of another unrelated problem. <input type="checkbox"/> Part- Time <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled. Explain cause/reason for disability:
<input type="checkbox"/> M <input type="checkbox"/> F	<b>AGE</b> <input type="text"/> <input type="text"/> <input type="text"/>
<b>JOB TITLE/OCCUPATION:</b>	
<b>EMPLOYER:</b>	

<b>WHICH SHOULDER IS BOTHERING YOU?</b> <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH	<b>I AM:</b> <input type="checkbox"/> RIGHT Hand Dominant <input type="checkbox"/> LEFT Hand Dominant <input type="checkbox"/> use both hands equally	
<b>HOW LONG HAVE YOU HAD THESE SYMPTOMS?</b> <input type="checkbox"/> No current symptoms <input type="checkbox"/> Less than one week <input type="checkbox"/> Less than 2 months <input type="checkbox"/> 2- 6 months <input type="checkbox"/> 6 months to 1 year. <input type="checkbox"/> 1 year to 3 years <input type="checkbox"/> 3 years to 5 years <input type="checkbox"/> greater than 5 years	<b>IF THERE WAS AN ACCIDENT, PLEASE DESCRIBE HOW IT HAPPENED?</b> <hr/> <hr/> <hr/>	
<b>PLEASE DESCRIBE YOUR CURRENT PROBLEM?</b> <input type="checkbox"/> This is a <b>NEW</b> injury. I have never had problems with my SHOULDER. <input type="checkbox"/> The symptoms <b>started slowly</b> and have progressively worsened. <input type="checkbox"/> I have had this problem for <b>many years</b> and the symptoms have stayed the same <input type="checkbox"/> This is a <b>re-injury</b> . Treatment was received in the past and was better until a new injury occurred.	<b>DATE of accident or onset of symptoms:</b> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>	
<b>IS THIS IS WORKMAN'S COMP CASE?</b> <input type="checkbox"/> yes <input type="checkbox"/> no	<b>HAVE YOU SEEN ANOTHER ORTHOPAEDIC DR. FOR YOUR SYMPTOMS?</b> <input type="checkbox"/> yes <input type="checkbox"/> no	<b>HAVE YOU CONSULTED A LAWYER ABOUT TODAY'S PROLEM?</b> <input type="checkbox"/> yes <input type="checkbox"/> no
<b>COMPARED TO 2 MONTHS AGO, HOW WOULD YOU RATE YOUR SYMPTOMS?</b> <input type="checkbox"/> No current symptoms <input type="checkbox"/> Much Better <input type="checkbox"/> Little Better <input type="checkbox"/> the same <input type="checkbox"/> Little Worse <input type="checkbox"/> Much Worse	<b>WHAT MAKES YOUR PAIN <u>WORSE</u>?</b> <input type="checkbox"/> OVERHEAD WORK <input type="checkbox"/> SPORTS or RECREATIONAL ACTIVITY <input type="checkbox"/> SLEEPING <input type="checkbox"/> Other: _____	<b>WHAT MAKES YOUR PAIN <u>BETTER</u>?</b> <input type="checkbox"/> MY PAIN IS LESS WHEN I AM ACTIVE <input type="checkbox"/> MY PAIN IS LESS IF I REST IT <input type="checkbox"/> MEDICATION <input type="checkbox"/> THERAPY <input type="checkbox"/> INJECTIONS <input type="checkbox"/> Other: _____

PLEASE MARK THE *BODY DIAGRAM* BELOW WITH AN "X" FOR SHARP PAIN or an "O" FOR NUMBNESS. MARK ALL AREAS THAT APPLY.



WHERE IS THE PAIN? PLEASE CHECK (X) ALL THOSE THAT APPLY:

- NECK
- TOP OF SHOULDER
- BACK OF SHOULDER
- SIDE OF SHOULDER
- UPPER-ARM
- PAIN THAT STARTS IN THE NECK AND GOES DOWN TO MY FINGERTIPS
- ELBOW
- FOREARM
- WRIST
- FINGERS

HOW INTENSE IS YOUR PAIN? IF '0' IS NO PAIN AND '10' IS SEVERE PAIN? Please circle a number that applies.

- Scale:
- 0 NONE
  - 1 MILD
  - 2 MILD
  - 3 TROUBLESOME UNCOMFORTABLE
  - 4 TROUBLESOME UNCOMFORTABLE
  - 5 DISTRESSING
  - 6 DISTRESSING
  - 7 HORRIBLE, INTENSE PAIN
  - 8 HORRIBLE, INTENSE PAIN
  - 9 UNBEARABLE, EXCRUTIATING
  - 10 UNBEARABLE, EXCRUTIATING

**MY SYMPTOMS ARE:**

- CONSTANT AND OCCURS EVERY DAY
- ARE INTERMITTENT BUT OCCUR EVERY DAY
- NOT PRESENT EVERY DAY

**MY PAIN IS BEST DESCRIBED AS:**

- SHARP SHOOTING
- DULL and ACHY
- BURNING

**MY PAIN DURING THE DAY IS :**

- None or I Ignore it.
- Slight, but no compromise in my activity. Pain improves with activity.
- MILD or OCCASIONAL pain. Pain is present more with unusual ACTIVITY, but disappears with rest.
- MODERATE PAIN, some limitations is usual activity at work or with exercise. Need to take medications regularly
- MODERATE pain during and after activities. NO pain at Rest (INTERMITTENT). Many limitations.
- MODERATE pain during and after activities. Many limitations.
- SEVERE pain, present constantly and intense. Many limitations. Nearly bed-ridden.

**INSTRUCTIONS for the DASH Score:** This questionnaire asks about your symptoms as well as you ability to perform certain activities. Please answer *every question*, based on your condition in the **last week**. If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on you ability regardless of how you perform the task.

**Please rate your ability to do the following activities in the last week.**

	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	Unable
1. Open a tight or new jar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Write	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Turn a key	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Prepare a meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Push open a heavy door	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Place an object on a shelf above your head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do heavy household chores (e.g. wash walls, wash floors)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Garden or do yard work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Make a bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Carry a shopping bag or briefcase	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Carry a heavy object (over 10 lbs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Change a light bulb overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Wash or blow dry your hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Wash your back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Put on a pullover sweater	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Use a knife to cut food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Recreational activities which require little effort (eg card playing, knitting, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (eg golf, hammering, tennis, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Recreational activities in which you move your arm freely (eg playing frisbee, badminton, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20.	Manage transportation needs (getting from one place to another)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21.	Sexual activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		<b>Not at all</b>	<b>Slightly</b>	<b>Moderately</b>	<b>Quite a bit</b>	<b>Extremely</b>
22.	During the past week, <i>to what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		<b>Not limited at all</b>	<b>Slightly limited</b>	<b>Moderately limited</b>	<b>Very limited</b>	<b>Unable</b>
23.	During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<b>Please rate the severity of the following symptoms in the last week</b>	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Extreme</b>
24.	Arm, shoulder or hand pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25.	Arm, shoulder or hand pain when you performed any specific activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26.	Tingling (pins and needles) in your arm, shoulder or hand	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27.	Weakness in your arm, shoulder or hand	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28.	Stiffness in your arm, shoulder or hand	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		<b>No difficulty</b>	<b>Mild difficulty</b>	<b>Moderate difficulty</b>	<b>Severe difficulty</b>	<b>So much difficulty I can't sleep</b>
29.	During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		<b>Strongly disagree</b>	<b>Disagree</b>	<b>Neither agree or disagree</b>	<b>Agree</b>	<b>Strongly agree</b>
30.	I feel less capable, less confident or less useful because of my arm, shoulder or hand problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## OXFORD SHOULDER SCORE

Please answer the following 12 multiple choice questions.

During the past 4 weeks.....

<b>1. How would you describe the worst pain you had from your shoulder?</b>	<b>2. Could you brush/comb your hair with the affected arm?</b>
<input type="radio"/> None	<input type="radio"/> Yes, easily
<input type="radio"/> mild	<input type="radio"/> With little difficulty
<input type="radio"/> Moderate	<input type="radio"/> With moderate difficulty
<input type="radio"/> Severe	<input type="radio"/> With extreme difficulty
<input type="radio"/> Unbearable	<input type="radio"/> No, impossible

<b>3. Have you had any trouble dressing yourself because of your shoulder?</b>	<b>4. How would you describe the pain you usually had from your shoulder?</b>
<input type="radio"/> No trouble at all	<input type="radio"/> None
<input type="radio"/> Little trouble	<input type="radio"/> Very mild
<input type="radio"/> Moderate trouble	<input type="radio"/> Mild
<input type="radio"/> Extreme difficulty	<input type="radio"/> Moderate
<input type="radio"/> Impossible to do	<input type="radio"/> Severe

<b>5. Have you had any trouble getting in and out of a car or using public transport because of your shoulder?</b>	<b>6. Could you hang your clothes up in a wardrobe, using the affected arm? (whichever you tend to use)</b>
<input type="radio"/> No trouble at all	<input type="radio"/> Yes, easily
<input type="radio"/> Very little trouble	<input type="radio"/> With little difficulty
<input type="radio"/> Moderate trouble	<input type="radio"/> With moderate difficulty
<input type="radio"/> Extreme difficulty	<input type="radio"/> With great difficulty
<input type="radio"/> Impossible to do	<input type="radio"/> No, impossible

<b>7. Have you been able to use a knife and fork – at the same time?</b>	<b>8. Have you been able to wash and dry yourself under both arms?</b>
<input type="radio"/> Yes, easily	<input type="radio"/> Yes, easily
<input type="radio"/> With little difficulty	<input type="radio"/> With little difficulty
<input type="radio"/> With moderate difficulty	<input type="radio"/> With moderate difficulty
<input type="radio"/> With extreme difficulty	<input type="radio"/> With extreme difficulty
<input type="radio"/> No, impossible	<input type="radio"/> No, impossible

**9. Could you do the household shopping on your own?**

<input type="checkbox"/>	Yes, easily
<input type="checkbox"/>	With little difficulty
<input type="checkbox"/>	With moderate difficulty
<input type="checkbox"/>	With extreme difficulty
<input type="checkbox"/>	No, impossible

**10. How much has pain from your shoulder interfered with your usual work (including housework)?**

<input type="checkbox"/>	Not at all
<input type="checkbox"/>	A little bit
<input type="checkbox"/>	Moderately
<input type="checkbox"/>	Greatly
<input type="checkbox"/>	Totally

**11. Could you carry a tray containing a plate of food across a room?**

<input type="checkbox"/>	Yes, easily
<input type="checkbox"/>	With little difficulty
<input type="checkbox"/>	With moderate difficulty
<input type="checkbox"/>	With extreme difficulty
<input type="checkbox"/>	No, impossible

**12. Have you been troubled by pain from your shoulder in bed at night?**

<input type="checkbox"/>	No nights
<input type="checkbox"/>	Only 1 or 2 nights
<input type="checkbox"/>	Some nights
<input type="checkbox"/>	Most nights
<input type="checkbox"/>	Every night

**PLEASE CHECK (X) ANY OF THE ANTI-INFLAMMATORY MEDICATIONS THAT YOU HAVE TRIED AND CIRCLE THOSE THAT YOU ARE CURRENTLY TAKING.**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Motrin/Ibuprofen/ <i>Advil</i> | <input type="checkbox"/> Tylenol/Acetaminophen           | <input type="checkbox"/> Tramadol/ <i>Ultram</i>     | <input type="checkbox"/> Glucosamine Chondroitin Sulfate |
| <input type="checkbox"/> Celebrex                       | <input type="checkbox"/> Indomethacin/ <i>Indocin</i>    | <input type="checkbox"/> Etodolac/ <i>Lodine</i>     | <input type="checkbox"/> Prednisone                      |
| <input type="checkbox"/> Vioxx                          | <input type="checkbox"/> Naproxen/Naprosyn/ <i>Aleve</i> | <input type="checkbox"/> Diclofenac/ <i>Voltaren</i> | <input type="checkbox"/> Other: _____                    |
| <input type="checkbox"/> Valdecoxib/ <i>Bextra</i>      | <input type="checkbox"/> Piroxicam/ <i>Feldene</i>       | <input type="checkbox"/> Oxaprozin/ <i>Daypro</i>    |  |
| <input type="checkbox"/> Aspirin                        | <input type="checkbox"/> Nabumetone/ <i>Relafen</i>      | <input type="checkbox"/> Mobic                       |  |

**PLEASE CHECK (X) ANY OF THE PAIN RELIEVING AND MUSCLE RELAXING MEDICATIONS THAT YOU HAVE TRIED AND CIRCLE THOSE THAT YOU ARE CURRENTLY TAKING.**

- |   |                                   |                                    |                                   |                                       |
|---|-----------------------------------|------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Codeine / Tylenol #3 | <input type="checkbox"/> Tylox    | <input type="checkbox"/> Methadone | <input type="checkbox"/> Soma     | <input type="checkbox"/> Robaxin      |
| <input type="checkbox"/> Vicodin/Hydrocodone  | <input type="checkbox"/> Percocet | <input type="checkbox"/> Dilaudid  | <input type="checkbox"/> Flexaril | <input type="checkbox"/> Zanaflex     |
| <input type="checkbox"/> Lortab               | <input type="checkbox"/> Percodan | <input type="checkbox"/> Demerol   | <input type="checkbox"/> Valium   | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Darvocet             | <input type="checkbox"/> Fioricet | <input type="checkbox"/> Roxicet   | <input type="checkbox"/> Skelaxin |                                       |

**PLEASE CHECK (X) ANY OF THE FOLLOWING SIDE EFFECTS YOU MAY HAVE EXPERIENCED WHILE TAKING THE ABOVE MEDICATIONS**

- |                                 |   |   |                                       |
|---------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> NONE   | <input type="checkbox"/> HEARTBURN or UPSET STOMACH | <input type="checkbox"/> STOOLS CHANGE COLOR (DARK) | <input type="checkbox"/> VOMITING     |
| <input type="checkbox"/> NAUSEA | <input type="checkbox"/> ULCERS                     | <input type="checkbox"/> DIARRHEA                   | <input type="checkbox"/> OTHER: _____ |

**DURING THE PAST 4 WEEKS HOW OFTEN HAVE YOU TAKEN MEDICATION FOR EACH JOINT?**

	RIGHT SHOULDER	LEFT SHOULDER
<b>ALWAYS (max dosage)</b>	<b>1</b>	<b>1</b>
<b>OFTEN (every day, but NOT maximum dosage)</b>	<b>2</b>	<b>2</b>
<b>SOMETIMES (3-5 times per week)</b>	<b>3</b>	<b>3</b>
<b>OCCASIONALLY(1-2 times per week)</b>	<b>4</b>	<b>4</b>
<b>NEVER</b>	<b>5</b>	<b>5</b>

**ARE THE MEDICATIONS THAT YOU ARE TAKING FOR YOUR PAIN RELIEVING YOUR SYMPTOMS?**

YES       NO

**HAVE YOU EVER BEEN TREATED AT A *PAIN CLINIC*?**

YES       NO

**PREVIOUS TREATMENT FOR YOUR RIGHT SHOULDER PAIN. PLEASE CHECK (X) those that apply.**

TREATMENT	RIGHT SHOULDER..... with relief				Last injection Date: _____	How many Treatments? _____
CORTISONE injection	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		_____
PHYSICAL THERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		How many Treatments? _____
ACCUPUNCTURE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		_____
CHIROPRACTIC CARE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		

**PREVIOUS TREATMENT FOR YOUR LEFT SHOULDER. PLEASE CHECK (X) those that apply.**

TREATMENT	LEFT SHOULDER..... with relief				Last injection Date: _____	How many Treatments? _____
CORTISONE injection	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		_____
PHYSICAL THERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		How many Treatments? _____
ACCUPUNCTURE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		_____
CHIROPRACTIC CARE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		

**PREVIOUS SURGERY TO THE SHOULDER(S):**

DATE OF SURGERY	WHICH SIDE?	SURGEON/Hospital	PROCEDURE	COMPLICATIONS
	R / L / BOTH			
	R / L / BOTH			
	R / L / BOTH			
	R / L / BOTH			

## SF36 Health Survey

**INSTRUCTIONS:** This set of questions 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. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

1. In general, would you say your health is: (Please tick **one** box.)

Excellent

Very Good

Good

Fair

Poor

2. Compared to one year ago, how would you rate your health in general now? (Please tick **one** box.)

Much better than one year ago

Somewhat better now than one year ago

About the same as one year ago

Somewhat worse now than one year ago

Much worse now than one year ago

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? **(Please circle one number on each line.)**

<u>Activities</u>	Yes, Limited A Lot	Yes, Limited A Little	Not Limited At All
3(a) <b>Vigorous activities</b> , such as running, lifting heavy objects, participating in strenuous sports	1	2	3
3(b) <b>Moderate activities</b> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
3(c) Lifting or carrying groceries	1	2	3
3(d) Climbing <b>several</b> flights of stairs	1	2	3
3(e) Climbing <b>one</b> flight of stairs	1	2	3
3(f) Bending, kneeling, or stooping	1	2	3
3(g) Walking <b>more than a mile</b>	1	2	3
3(h) Walking <b>several blocks</b>	1	2	3
3(i) Walking <b>one block</b>	1	2	3
3(j) Bathing or dressing yourself	1	2	3

4. 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? **(Please circle one number on each line.)**

<u>Problems</u>	Yes	No
4(a) Cut down on the <b>amount of time</b> you spent on work or other activities	1	2
4(b) Accomplished less than you would like	1	2
4(c) Were <b>limited</b> in the <b>kind</b> of work or other activities	1	2
4(d) Had <b>difficulty</b> performing the work or other activities (for example, it took extra effort)	1	2

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 any emotional problems (e.g. feeling depressed or anxious)? **(Please circle one number on each line.)**

<u>Problems</u>	Yes	No
5(a) Cut down on the <b>amount of time</b> you spent on work or other activities	1	2
5(b) Accomplished less than you would like	1	2
5(c) Didn't do work or other activities as <b>carefully</b> as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups? (Please tick **one** box.)

Not at all

Slightly

Moderately

Quite a bit

Extremely

7. How much physical pain have you had during the past 4 weeks? (Please tick **one** box.)

None

Very mild

Mild

Moderate

Severe

Very Severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Please tick **one** box.)

Not at all

A little bit

Moderately

Quite a bit

Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

**(Please circle one number on each line.)**

	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(a) Did you feel full of life?	1	2	3	4	5	6
9(b) Have you been a very nervous person?	1	2	3	4	5	6
9(c) Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
9(d) Have you felt calm and peaceful?	1	2	3	4	5	6
9(e) Did you have a lot of energy?	1	2	3	4	5	6
9(f) Have you felt downhearted and blue?	1	2	3	4	5	6
9(g) Did you feel worn out?	1	2	3	4	5	6
9(h) Have you been a happy person?	1	2	3	4	5	6
9(i) Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives etc.) (Please tick **one** box.)

All of the time

Most of the time

Some of the time

A little of the time

None of the time

11. How TRUE or FALSE is each of the following statements for you?

**(Please circle one number on each line.)**

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
11(a) I seem to get sick a little easier than other people	1	2	3	4	5
11(b) I am as healthy as anybody I know	1	2	3	4	5
11(c) I expect my health to get worse	1	2	3	4	5
11(d) My health is excellent	1	2	3	4	5

**Thank You!**

Which ONE of the following includes the highest level of formal schooling that you have had?

- No Formal Schooling
- Elementary School
- High School
- Some College
- College Degree
- Graduate School

Are You married?

- Yes, married
- No, Never married
- No, divorced or separated
- No, widowed

Which ONE of the following best describes your living current living arrangement?

- I live alone in a house or apartment
- I live with my family in a house or apartment
- Assisted Living Center: *Location* \_\_\_\_\_
- Nursing Home: *Location* \_\_\_\_\_
- other (please Describe) \_\_\_\_\_

## SOCIAL HABITS

DO YOU USE TOBACCO PRODUCTS?

YES NO.

- CHEWING TOBACCO  CIGARS  CIGARETTES  PIPE

If **yes**, how many packs/cigars a day? \_\_\_\_\_. About what year did you start? \_\_\_\_\_.

HAVE YOU EVER USED TOBACCO?

YES NO.

If **yes**, how many years? \_\_\_\_\_. About what year did you quit? \_\_\_\_\_.

DO YOU DRINK ALCOHOL SOCIALLY?

YES NO.

If **yes**, how many drinks per week? \_\_\_\_\_.

DO YOU FEEL YOU DRINK ALCOHOL IN EXCESS?

YES NO.

DO YOU USE RECREATIONAL DRUGS?

YES NO.

HAVE YOU EVER USED RECREATIONAL DRUGS?

YES NO.

DO YOU HAVE ANY **ALLERGIES** TO MEDICATIONS?

YES NO.

- Penicillin  Sulfa  Codeine  Betadine  
 OTHER \_\_\_\_\_

DO YOU HAVE AN **ALLERGY** TO LATEX?

YES NO.

DO YOU HAVE ANY **ALLERGIES** TO FOOD?

YES NO.

## MEDICAL PROBLEMS (see next page): check all that apply, Now or in the Past

- I HAVE **NOT** HAD ANY MEDICAL PROBLEMS OR PREVIOUS ILLNESSES

<b>General</b>	NOW	PAST	<b>Respiratory</b>	NOW	PAST	<b>GU (men)</b>	NOW	PAST
Fever			Shortness of breath (SOB)			Testicular pain or masses		
Chills			Asthma			<b>GU (women)</b>		
Drenching night sweats			COPD/Emphysema			Irregular menses/amenorrhea		
Itching			T.B.			Dysmenorrhea		
Fatigue			Positive PPD or prior BCG			Hot flashes		
Change in weight			Pneumonia or bronchitis			Pregnancy loss		
Change in appetite			Wheezing			<b>Extremities-muscles-joints</b>		
HIV/AIDS			Chronic Cough			Osteoarthritis		
Alcoholism			Hemoptysis			Rheumatoid Arthritis		
Fibromyalgia			Pulmonary embolus			Gout		
<b>Skin</b>			Sleep apnea			Morning stiffness		
Jaundice			Any abnormal chest X-ray in past			Joint injuries		
Skin cancer (what kind)			<b>Cardiovascular</b>			Raynaud's		
Psoriasis			High Blood pressure			Morning stiffness		
Eczema			Chest pain or Angina			Back pain		
<b>Head</b>			Heart attack			Neck pain		
Headache/migraines			Murmur			<b>Neurologic</b>		
Other head pain			arrhythmia			Seizures or epilepsy		
Trauma			Atrial Fibrillation			Stroke		
Skull fracture			Normal Stress Test			Dizziness or vertigo		
<b>Ears</b>			Abnormal Stress Test			Tremor		
Decreased hearing			Dizziness			Involuntary movements		
Tinnitus or ringing			Syncope or near-syncope			Balance problems		
Discharge			Loss of consciousness			Numbness or tingling in Feet		
Infection			Edema or swelling in both feet			Numbness or tingling in Hands		
Pain			Blood clots			Memory concerns		
<b>Eyes</b>			<b>Abdominal</b>			<b>Endocrine</b>		
Pain			Pain			Thyroid problems		
Infection			Nausea/vomiting			Heat or cold intolerance		
Glaucoma			Change in bowel habits			Diabetes Type I ( Insulin Requiring		
Dry eyes			Diarrhea or constipation			Diabetes Type II ( oral medications)		
Macular degeneration			Bright red blood per rectum			Diabetes-borderline		
blindness			History of polyps			Excessive thirst		
<b>Nose</b>			Colon cancer			Frequent Fractures		
Frequent bleeding			Pancreatitis			Loss of height		
Sinus Problems			Gall bladder disease			<b>Hematologic</b>		
Changes in smell			Gallstones			Anemia		
<b>Mouth/Throat</b>			Irritable bowel syndrome (IBS)			Sickle Cell Disease		
Tongue problems			Inflammatory bowel disease (IBD)			Swollen lymph nodes		
Change in taste			Hepatitis			Blood diseases		
Mouth lesions or ulcers			Hernias			Leukemia/lymphoma		
Dentures			<b>GU</b>			Bleeding problems		
Dry mouth			Frequency			Blood clots		
Bleeding(mouth/gums)			Burning			Past use of blood thinners		
Gum disease			Blood in the urine			<b>Psychiatric</b>		
Problems swallowing			Kidney stones			Depressive symptoms (e.g. feeling down)		
<b>Neck</b>			Urinary tract infection (UTI)			Anxious		
Thyroid problems			Cystitis			Phobias		
Lumps, masses, nodules			Incontinence			OCD behaviors		
<b>Breasts</b>			Bladder cancer			ADD/ADHD behaviors		
Masses			Prostate cancer			Panic attacks		
Discharge			Uterus/cervical cancer			Hallucinations (visual/auditory)		
Pain						Suicidal/homicidal thoughts		
Cancer						Bipolar Disorder		

**MEDICATIONS:** Please list all medications you are taking including over-the-counter medications.

**I DO NOT TAKE ANY MEDICATION**

MEDICATION	DOSEAGE	HOW OFTEN
1.		
2.		
3.		
4.		

MEDICATION	DOSEAGE	HOW OFTEN
5.		
6.		
7.		
8.		

**PERSONAL SURGICAL HISTORY**

**I HAVE NEVER HAD SURGERY**

PLEASE CHECK ALL THAT APPLY AND GIVE APPROXIMATE **YEAR** SURGERY WAS PERFORMED.

**ABDOMINAL SURGERY:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> APPENDIX              | <input type="checkbox"/> GASTRIC BYPASS               | <input type="checkbox"/> ORGAN TRANSPLANT |
| <input type="checkbox"/> GALL BLADDER REMOVAL  | <input type="checkbox"/> COLON RESECTION or COLOSTOMY |   |
| <input type="checkbox"/> HERNIA REPAIR         | <input type="checkbox"/> NISSEN (reflux surgery)      |   |
| <input type="checkbox"/> AORTIC ANEURYSM (AAA) | <input type="checkbox"/> REMOVAL OF SPLEEN            |   |

**CARDIO-VASCULAR SURGERY:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> ANGIOPLASTY or STENT  | <input type="checkbox"/> OPEN HEART SURGERY and BYPASS | <input type="checkbox"/> OPEN HEART SURGERY and VALVE SURGERY |
| <input type="checkbox"/> ARTERY BYPASS IN LEGS | <input type="checkbox"/> VEIN STRIPPING                | <input type="checkbox"/> CAROTID (neck) ARTERY SURGERY        |

**MUSCULOSKELETAL:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> CARPAL TUNNEL SURGERY | <input type="checkbox"/> FRACTURE REPAIR             | <input type="checkbox"/> JOINT RELACEMENT SURGERY  |
| <input type="checkbox"/> ARTHROSCOPY SURGERY   | <input type="checkbox"/> CERVICAL/NECK SPINE SURGERY | <input type="checkbox"/> LUMBAR/LOWER BACK SURGERY |

**OTHER:**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> THYROID REMOVAL | <input type="checkbox"/> CATARACT SURGERY | <input type="checkbox"/> BRAIN SURGERY | <input type="checkbox"/> LASIX EYE SURGERY |
| <input type="checkbox"/> TONSILLECTOMY   | <input type="checkbox"/> PLASTIC SURGERY  | <input type="checkbox"/> SINUS SURGERY |  |

**FEMALES ONLY:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> HYSTERECTOMY (uterus)  | <input type="checkbox"/> TUBAL LIGATION             | <input type="checkbox"/> C-SECTION                   |
| <input type="checkbox"/> OOPHORECTOMY (ovaries) | <input type="checkbox"/> BLADDER SUSPENSION SURGERY | <input type="checkbox"/> BREAST BIOSPY or MASTECTOMY |

**MALES ONLY:**

- |  |                                    |   |
|--|------------------------------------|---|
| <input type="checkbox"/> PROSTATE SURGERY            | <input type="checkbox"/> VASECTOMY | <input type="checkbox"/> TESTICULAR SURGERY |
| <input type="checkbox"/> BREAST BIOSPY or MASTECTOMY |                                    |   |

**OTHER SURGERY NOT LISTED ABOVE:**

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY :** DOES YOUR GRANDPARENTS, MOTHER, FATHER OR BROTHERS/ SISTERS OR CHILDREN HAVE ANY ON THE FOLLOWING MEDICAL PROBLEMS (LIVING OR DECEASED)?

Disease or Problem	yes	no	Relation
CANCER			
ANESTHESIA PROBLEMS			
TUBERCULOSIS			
Kidney problems			

Disease or Problem	yes	no	Relation
HEART DISEASE			
BLEEDING PROBLEMS			
CLOTTING PROBLEMS			
JOINT REPLACEMENT			

**SIGN HERE**

\_\_\_\_\_  
Signature of person filling out this form

**OFFICE USE ONLY:**

	RIGHT SHOULDER	LEFT SHOULDER
Act/Pass FORW. FLEX	/	/
Act/Pass ABDUC	/	/
Act/Pass E.R.	/	/
LEVEL OF I.R.		
ABDUCTION MMT		
IR MMT		
ER MMT		
A/C Tenderness		
Hawkins		
Impinge sign		
O'Brien's		
sulcus		
Apprehension		

\_\_\_\_\_  
Doctor's or Assistant's signature

\_\_\_\_\_  
date