# Shoulder Elbow Patient History



15666

Medical Record Number

Date of Visit ___ / ___ / ____

First Name ____ Middle ____ Last Name ____ Suffix ○ Sr. ○ Jr. ○ III ○ IV ○ M.D. ○ PhD

Date of Birth ___ / ___ / ____ (month / day / year (4 digit ex. 1922))

Social Security Number ___ - ___ - ____

**Gender**
○ Female ○ Male

Race
○ African American ○ Asian ○ Caucasian ○ Hispanic ○ Native American ○ Other_____

Marital Status
○ Single ○ Married ○ Living with significant other ○ Divorced ○ Separated ○ Widowed

Location of Problem
☐ Right shoulder ☐ Right elbow ☐ Left shoulder ☐ Left elbow

If you are seeing us for more than one problem, which ONE is the worst?
○ Right shoulder ○ Right elbow ○ Left shoulder ○ Left elbow

Please describe your current problem? (If you are seeing the doctor for multiple problems, answer for the most severe)
○ New Injury or problem (less than 6 weeks duration)
○ Subacute problem (began slowly with no identifiable cause and progressively worsened)
○ Chronic problem (problem has been present over time period of more than 3 months and never been restored to normal)
○ Re-injury (you injured this same area before, received treatment, had no problems until this new injury occurred)

Date problem began (approximate if unsure) ___ / ___ / ____ (month / day / year)

Date of re-injury ___ / ___ / ____ (month / day / year)

Is your problem a result of an injury? ○ Yes ○ No

***ANSWER THE QUESTIONS IN THIS BOX ONLY IF YOUR PROBLEM IS THE RESULT OF AN INJURY***

If your problem is the result of an injury, where did it occur? (check one answer only)
○ Home ○ Work ○ Motor vehicle accident ○ Exercise ○ Sport Competition ○ Other (specify)_____

What caused your injury?
☐ Fall ☐ Fighting
☐ Lifting ☐ Twisting
☐ Throwing ☐ Collision/Contact
☐ Reaching ☐ Other (specify)_____
☐ Pulling

Check any of the following that happened at the time of your injury
☐ Felt pain ☐ Heard popping ☐ Had swelling ☐ Dislocation ☐ Fracture ☐ Other (specify)_____

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 treatment type **(check all that apply)** and provide the **# of the procedures** or **weeks of physical therapy** you have had for the specific problem you are seeing the doctor for today*

☐ ER Visit
☐ oral medicine
☐ physical therapy # of weeks ___
☐ surgical # of surgeries ___
☐ injections # of injections ___
☐ chiropractic
☐ massage therapy
☐ acupuncture
☐ other_____ (specify)

**Please tell us your height and weight** Height ___ ft ___ inches Weight ___ pounds

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Physician you are seeing today (write only first and last name, do not write "Dr.")

Referring Physician (write only first and last name, do not write "Dr.")

## ***Review of Systems***

Please check all problems you currently experience - You may check more than one answer for each category.
If a problem does not apply to you DO NOT put any marks in the box.

☐ **Check this box if none of the following symptoms apply to you**

**Overall General Health**
- ☐ recent weight gain
- ☐ recent weight loss
- ☐ appetite change
- ☐ difficulty sleeping

**Endocrine & Metabolic**
- ☐ sugar diabetes
- ☐ goiter
- ☐ thyroid problem
- ☐ cholesterol / lipid problem

**Blood (Hematopoietic / Lymphatic)**
- ☐ anemia
- ☐ lymph node enlargement
- ☐ bleeding problem
- ☐ frequent infections

**Psychiatric**
- ☐ anxiety
- ☐ depression
- ☐ been seen by a psychiatrist

**Lungs (Respiratory)**
- ☐ shortness of breath
- ☐ cough
- ☐ sputum
- ☐ bronchitis
- ☐ asthma
- ☐ night sweats

**Brain, Nerves, Spinal Cord (Neurologic)**
- ☐ headaches
- ☐ dizziness
- ☐ blackouts
- ☐ numbness and tingling
- ☐ paralysis
- ☐ convulsions / seizures
- ☐ coordination trouble

**Kidney, Bladder, Reproductive (Genitourinary)**
- ☐ burning on urination
- ☐ frequency of urination
- ☐ difficulty starting urine
- ☐ wetting pants or bed
- ☐ bloody urine
- ☐ sexual difficulties

**Heart & Blood Vessels (Cardiovascular)**
- ☐ chest pain
- ☐ heart attack
- ☐ palpitations (irregular heart beat)
- ☐ heart failure
- ☐ edema (leg swelling)
- ☐ high blood pressure
- ☐ leg cramps with walking

**Abdomen (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

**Bone & Joint (Musculoskeletal)**
- ☐ joint pain
- ☐ joint swelling or warmth
- ☐ joint stiffness
- ☐ muscle pain
- ☐ weakness
- ☐ back pain
- ☐ joint deformity

***IN ORDER TO INSURE PROPER AND COMREHENSIVE CARE, YOU MUST FOLLOW-UP WITH YOUR PRIMARY CARE PHYSICIAN FOR ANY AND ALL MEDICAL PROBLEMS AND CONCERNS CHECKED HERE***

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·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.**

**Medical Condition History** Check this box if you have **no** medical problems ☐ no medical problems

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis - rheumatoid (verified with blood test)
- ☐ Arthritis - osteo, degenerative
- ☐ Blood Clot Year ☐☐☐☐
- ☐ Blood Transfusion Year ☐☐☐☐
- ☐ Bowel disease
- ☐ Cancer (specify)_____
- ☐ Cardiac Arrhythmia (Abnormal heart rate)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease (Angina)
- ☐ Cerebrovascular Disease (Stroke)
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Diabetes
- ☐ Depression
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Gout
- ☐ Heart Attack Year ☐☐☐☐
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypercholesterolemia (Elevated Cholesterol)
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disorder - Cirrhosis
- ☐ Liver Disorder - Hepatitis
- ☐ Lung Disease
- ☐ Osteomyelitis
- ☐ Parkinson's
- ☐ Ulcer Disease
- ☐ Other (specify all other)_____

**Surgery/ Procedures** These are non-orthopaedic procedures. Please check any procedures you have had and give the year.

***Have you ever had surgery?*** ○ Yes ○ No

***Ear, Nose, Throat Surgeries***

- ☐ Deviated Septum ☐☐☐☐
- ☐ Sinus Repair ☐☐☐☐
- ☐ Tonsillectomy ☐☐☐☐
- ☐ Tracheostomy ☐☐☐☐
- ☐ Vocal Cord Surgery ☐☐☐☐

***Gastrointestinal Surgeries***

- ☐ Appendectomy ☐☐☐☐
- ☐ Cholecystectomy (Gallbladder removed) ☐☐☐☐
- ☐ Colon Resection ☐☐☐☐
- ☐ Exploratory Laproscopy ☐☐☐☐
- ☐ Hernia ○ Femoral ○ Incisional ○ Inguinal ○ Umbilical ☐☐☐☐
- ☐ Liver Resection ☐☐☐☐
- ☐ Small Bowel Obstruction Repair ☐☐☐☐
- ☐ Splenectomy ☐☐☐☐

***Gynecologic Surgeries***

- ☐ Hysterectomy ☐☐☐☐
- ☐ Oophorectomy ☐☐☐☐
- ☐ Ruptured ectopic ☐☐☐☐
- ☐ Laprascopy ☐☐☐☐
- ☐ C-Section ☐☐☐☐

***Urologic Surgeries***

- ☐ Bladder Suspension ☐☐☐☐
- ☐ Bladder Removed ☐☐☐☐
- ☐ Lithotripsy (Stone Machine) ☐☐☐☐
- ☐ Prostatectomy (Prostate Removed) ☐☐☐☐
- ☐ Vasectomy ☐☐☐☐

***General Surgeries***

- ☐ Breast Biopsy ○ Right ○ Left ○ Bilateral ☐☐☐☐
- ☐ Mastectomy ○ Right ○ Left ○ Bilateral ☐☐☐☐
- ☐ Thyroid Surgery ☐☐☐☐
- ☐ Whipple ☐☐☐☐

***Heart (Cardiac) Surgeries***

- ☐ CABG # arteries ○ 1 ○ 2 ○ 3 ○ 4 ○ 4+ ☐☐☐☐
- ☐ Valve ○ Aortic ○ Mitral ○ Tricuspid ☐☐☐☐
- ☐ Angioplasty ☐☐☐☐
- ☐ Defibrillator ☐☐☐☐
- ☐ Pace Maker ☐☐☐☐

***Vascular Surgeries***

- ☐ Bypass Graft - Legs ☐☐☐☐
- ☐ Vascular Access ☐☐☐☐
- ☐ AAA ☐☐☐☐
- ☐ Thoracic Aneurysm ☐☐☐☐

***Thoracic Surgeries***

- ☐ Chest Tube ☐☐☐☐
- ☐ Pulmonary ☐☐☐☐
- ☐ Pectus ☐☐☐☐

***Neurosurgeries***

- ☐ Brain Tumor ○ Malignant ○ Benign ☐☐☐☐
- ☐ Brain Aneurysm ☐☐☐☐
- ☐ Chiari Decompression ☐☐☐☐
- ☐ Spinal Cord Tumor ○ Malignant ○ Benign ☐☐☐☐
- ☐ Epidural Injection ☐☐☐☐
- ☐ Abcess ☐☐☐☐
- ☐ Stent ☐☐☐☐

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**Orthopaedic Surgery/ Procedures** Please check any procedures you have had and give the year.

Most Recent Year | Previous Surgery Year (if same surgery performed more than once)

***Broken Bones/Fracture Repair Surgeries***

- ☐ Fracture Repair - Finger ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Hand ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Wrist ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Arm ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Elbow ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Shoulder ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Hip/Pelvis ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Femur ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Knee ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Lower Leg ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Ankle/Foot ○ Right ○ Left ○ Bilateral

***Ankle/Foot Surgeries***

- ☐ Ankle Arthroscopy ○ Right ○ Left ○ Bilateral
- ☐ Ankle Fusion ○ Right ○ Left ○ Bilateral
- ☐ Tendon Surgery ○ Right ○ Left ○ Bilateral
- ☐ Toe Surgery specify _____ ○ Right ○ Left ○ Bilateral

***Elbow, Wrist, Hand Surgeries***

- ☐ Biceps Repair ○ Right ○ Left ○ Bilateral
- ☐ Carpal Tunnel Surgery ○ Right ○ Left ○ Bilateral
- ☐ Elbow Arthroscopy ○ Right ○ Left ○ Bilateral
- ☐ Elbow Ligament Reconstruction ○ Right ○ Left ○ Bilateral
- ☐ Elbow Replacement ○ Right ○ Left ○ Bilateral
- ☐ Hand Tendon Repair ○ Right ○ Left ○ Bilateral
- ☐ Nail Bed Surgery ○ Right ○ Left ○ Bilateral
- ☐ Tennis Elbow Surgery ○ Right ○ Left ○ Bilateral
- ☐ Trigger Finger Surgery ○ Right ○ Left ○ Bilateral
- ☐ Wrist Ligament Reconstruction ○ Right ○ Left ○ Bilateral

***Knee Surgeries***

- ☐ Knee Arthroscopy ○ Right ○ Left ○ Bilateral
- ☐ Cartilage surgery/meniscus surgery ○ Right ○ Left ○ Bilateral
- ☐ Knee replacement ○ Right ○ Left ○ Bilateral
- ☐ Ligament reconstruction - ACL ○ Right ○ Left ○ Bilateral
- ☐ Ligament reconstruction - other ○ Right ○ Left ○ Bilateral

***Hip Surgeries***

- ☐ Hip replacement ○ Right ○ Left ○ Bilateral
- ☐ AVN Surgery ○ Core Decompression ○ Fibular Graft ○ Right ○ Left ○ Bilateral

***Shoulder Surgeries***

- ☐ Shoulder Arthroscopy ○ Right ○ Left ○ Bilateral
- ☐ Rotator cuff surgery ○ Right ○ Left ○ Bilateral
- ☐ Shoulder replacement ○ Right ○ Left ○ Bilateral
- ☐ Shoulder stabilization ○ Right ○ Left ○ Bilateral

***Spine Surgeries***

- ☐ Laminectomy ☐ Cervical ☐ Lumbar ☐ Thoracic
- ☐ Anterior Fusion ☐ Cervical ☐ Lumbar ☐ Thoracic
- ☐ Posterior Fusion ☐ Cervical ☐ Lumbar ☐ Thoracic
- ☐ Posterior Discectomy ☐ Cervical ☐ Lumbar ☐ Thoracic

***Other*** *(List all other surgeries)* _____

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## Drug Allergy and Medication Information

Have you ever had problems with anesthesia? ○ Yes ○ No *If yes, describe*_____

Are you allergic to latex? ○ Yes ○ No

Are you allergic to any medications? ○ Yes ○ No *If yes, please write the name of the drug in the boxes below and check the reaction you experienced. Please write only one drug in each space provided. If you have more than 3 drug allergies list the others in the space provided.*

Specify Drug:

Describe: ☐ shock ☐ breathing problems ☐ rash ☐ nausea ☐ other_____

Specify Drug:

Describe: ☐ shock ☐ breathing problems ☐ rash ☐ nausea ☐ other_____

Specify Drug:

Describe: ☐ shock ☐ breathing problems ☐ rash ☐ nausea ☐ other_____

Please list additional drug allergies here: _____

_____

**Please list the medications you are currently taking** - *Please include prescription and non-prescription medication*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please check any anti-inflammatory medication listed below which you have taken in the past. Please include all prescription, non-prescription and samples

☐ Advil
☐ Arthrotec
☐ Bextra
☐ Celebrex
☐ Daypro
☐ Ibuprofen
☐ Indocin
☐ Lodine
☐ Naprelan
☐ Naproxen
☐ Oruval/Orudis
☐ Tylenol
☐ Ultram
☐ Vioxx
☐ 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 ☐ Pepcid ☐ Prevacid ☐ Prilosec ☐ Tagamet ☐ Zantac

## Family Medical History

Please check all diseases for which you have a family history:

☐ Cancer - Breast
☐ Cancer - Prostate
☐ Cancer - Other
☐ Diabetes
☐ Heart Disease
☐ Stroke
☐ Rheumatoid Arthritis
☐ Arthritis - osteo, degenerative
☐ Gout
☐ Lupus

If you know your parents' health history please provide the information below. Otherwise, please leave blank.

Father ○ alive ○ deceased Age (current age or age deceased)

Health history ☐ cancer ☐ heart disease ☐ stroke ☐ diabetes ☐ rheumatoid arthritis ☐ osteoarthritis ☐ gout ☐ lupus

Cause of death (if deceased)

Mother ○ alive ○ deceased Age (current age or age deceased)

Health history ☐ cancer ☐ heart disease ☐ stroke ☐ diabetes ☐ rheumatoid arthritis ☐ osteoarthritis ☐ gout ☐ lupus

Cause of death (if deceased)

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**Social History**

Current Employment (Check only ONE answer)

- ○ full time
- ○ part time
- ○ retired
- ○ student
- ○ unemployed
- ○ paid leave
- ○ unpaid leave
- ○ disabled by back/neck
- ○ disabled by today's problem
- ○ disabled NOT by today's problem

Level of Education (Check only ONE answer)

- ○ grade school
- ○ high school/equivalent
- ○ some college
- ○ college degree
- ○ graduate degree

Job Title

Alcohol

- ○ I drink alcohol
- ○ I do not drink alcohol, but I used to drink alcohol
- ○ I never drank alcohol

If you drink alcohol, how frequently?

- ○ 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)

Tobacco

- ○ I use tobacco
- ○ I do not use tobacco, but I used to use tobacco
- ○ I have never used tobacco

If you use or used to use tobacco, cigarette packs per day

- ☐ 1/2
- ☐ 1
- ☐ 1 and 1/2
- ☐ 2
- ☐ 2 and 1/2
- ☐ 3
- ☐ 3 and 1/2
- ☐ 4

Years of tobacco use ☐☐

Do you exercise regularly?

○ Yes ○ No

If you exercise, how often?

○ daily ○ 3 times per week ○ weekly ○ at least once every other week

**Symptoms and Pain Survey**

Duration of current symptoms:

- ○ no current symptoms
- ○ <1 week
- ○ 1-3 weeks
- ○ 3-6 weeks
- ○ 6 weeks-3months
- ○ 3-6months
- ○ 6months-1year
- ○ 1-3 years
- ○ 3-5 years
- ○ >5 years

Compared to 3 months ago, how would you rate your symtoms now?

○ much worse ○ a little worse ○ same ○ a little better ○ much better

Compared to 3 months ago, how worried are you about your condition now?

○ much less worried ○ less worried ○ no change ○ more worried ○ much more worried

Are you having pain today? ○ yes ○ no Is your pain today - ○ occasional ○ continuous/constant

On a scale of 0-10 (with 10 being the worst pain imaginable), how would you score your pain today?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Check the words that best describe the character of the pain you are having today.

- ☐ aching
- ☐ throbbing
- ☐ shooting
- ☐ stabbing
- ☐ gnawing
- ☐ sharp
- ☐ tender
- ☐ burning
- ☐ exhausting
- ☐ tiring
- ☐ penetrating
- ☐ nagging
- ☐ numb
- ☐ miserable
- ☐ unbearable

Does the pain awaken you from sleep?

○ never ○ occasionally ○ frequently

Does the pain keep you from sleeping?

○ never ○ occasionally ○ frequently

What time of day is your pain worst (CHECK ONLY ONE)?

○ morning ○ afternoon ○ evening ○ nighttime ○ all the time

What makes your pain better?

- ☐ rest
- ☐ medication
- ☐ ice
- ☐ heat
- ☐ sitting
- ☐ lying down
- ☐ walking
- ☐ standing
- ☐ nothing in particular
- ☐ other (specify)_____

What makes your pain worse?

- ☐ sitting
- ☐ standing
- ☐ lying down
- ☐ walking
- ☐ exercising
- ☐ activity in general
- ☐ stooping/bending
- ☐ nothing in particular
- ☐ other (specify)_____

**If you had to spend the rest of your life with your condition the way it is now, how would you feel about it?**

○ Delighted ○ Pleased ○ Mostly satisfied ○ Mixed ○ Mostly dissatisfied ○ Unhappy ○ Terrible

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# MASES Shoulder (or Elbow) Patient Questionnaire

**Please** mark **ONLY ONE** answer for each question

☐ Check this box if you are seeing the doctor for your Elbow and answer each question below

***Otherwise, leave this box blank and answer all the questions below for your shoulder***

How would you rate your upper extremity today as a percentage of normal (0% - 100%, with 100% being normal)? ☐☐☐ %

Do you have mechanical symptoms (catching, locking or grinding in your joint)? ○ Yes ○ No

**Hand Dominance:** ○ **Right** ○ **Left** ○ **Use both equally**

Are you having pain in your shoulder (elbow)? ○ Yes ○ No

Do you have pain in your shoulder (elbow) at night? ○ Yes ○ No

Do you take pain medication (aspirin, Advil, Tylenol, ect.)? ○ Yes ○ No

Do you take narcotic pain medication (codeine or stronger)? ○ Yes ○ No

How many pills do you take each day for your pain (average)? ☐☐

Does your shoulder (elbow) feel unstable (as it is going to dislocate)? ○ Yes ○ No

How unstable is your shoulder (elbow)? **(PLEASE MARK A NUMBER)**

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

very stable — very unstable

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. Getting dressed putting on your coat | ○ 0 ○ 1 ○ 2 ○ 3 | ○ 0 ○ 1 ○ 2 ○ 3 |
| 2. Wash back / do up bra | ○ 0 ○ 1 ○ 2 ○ 3 | ○ 0 ○ 1 ○ 2 ○ 3 |
| 3. Manage toileting | ○ 0 ○ 1 ○ 2 ○ 3 | ○ 0 ○ 1 ○ 2 ○ 3 |
| 4. Comb hair | ○ 0 ○ 1 ○ 2 ○ 3 | ○ 0 ○ 1 ○ 2 ○ 3 |
| 5. Reach a high shelf | ○ 0 ○ 1 ○ 2 ○ 3 | ○ 0 ○ 1 ○ 2 ○ 3 |
| 6. Lifting heavy objects | ○ 0 ○ 1 ○ 2 ○ 3 | ○ 0 ○ 1 ○ 2 ○ 3 |
| 7. Open a jar of food | ○ 0 ○ 1 ○ 2 ○ 3 | ○ 0 ○ 1 ○ 2 ○ 3 |
| 8. Cut with a knife | ○ 0 ○ 1 ○ 2 ○ 3 | ○ 0 ○ 1 ○ 2 ○ 3 |
| 9. Use a phone | ○ 0 ○ 1 ○ 2 ○ 3 | ○ 0 ○ 1 ○ 2 ○ 3 |
| 10. Carry shopping | ○ 0 ○ 1 ○ 2 ○ 3 | ○ 0 ○ 1 ○ 2 ○ 3 |
| 11. Do up buttons | ○ 0 ○ 1 ○ 2 ○ 3 | ○ 0 ○ 1 ○ 2 ○ 3 |
| 12. Do usual work | ○ 0 ○ 1 ○ 2 ○ 3 | ○ 0 ○ 1 ○ 2 ○ 3 |

Describe usual work:

13. Do usual sport ○ 0 ○ 1 ○ 2 ○ 3 ○ 0 ○ 1 ○ 2 ○ 3

Describe usual sport:

**If you have had surgery, please answer the following questions. Otherwise, please leave them blank.**

Does your operated arm feel numb in any region? ○ Yes ○ No

Does your operated arm feel weaker to any activity now than before? ○ Yes ○ No

Does your operated arm feel more painful now than before surgery? ○ Yes ○ No

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## 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

**(#2 and #3)** 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 |

**(#4 and #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 your physical health?

| | Yes | No |
|---|---|---|
| 4. Accomplished less than you would like | ○ 1 | ○ 2 |
| 5. Were limited in the kind of work or other activities | ○ 1 | ○ 2 |

**(#6 and #7)** 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)?

| | Yes | No |
|---|---|---|
| 6. Accomplished less than you would like | ○ 1 | ○ 2 |
| 7. Didn't do work or perform other activities as carefully as usual | ○ 1 | ○ 2 |

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

**(#9, #10 and #11)** 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 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)?

| All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|---|---|---|---|---|
| ○ 1 | ○ 2 | ○ 3 | ○ 4 | ○ 5 |

***PLEASE RETURN THIS COMPLETED PACKET TO THE FRONT DESK NOW***