UW Medicine - Hand, Elbow, Shoulder

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Your Name: _____ Age _____ Today's Date: _____

Primary Care Doctor: _____

Are you: ☐Right handed? ☐Left handed? ☐Ambidextrous?

Your referral: Were you:

☐Referred by your primary care doctor?

☐Referred by another doctor? Referring doctor, if known: _____

☐Self-referred? How did you hear about us? _____

YOUR PROBLEM FOR THE VISIT TODAY: Describe the main problem for the visit today:

_____

_____

What body part is most affected? _____ Which side? ☐Right, ☐Left, ☐Both

What bothers you about your problem? (**check ANY that apply**)

☐Pain, ☐Loss of mobility (stiffness), ☐Loss of sensation, ☐Loss of strength, ☐Feels "unstable", ☐Bump or mass

☐Other _____

What bothers you **the MOST** about your problem? (**pick ONE** of the above): _____

When did this problem start (Date of Injury)?: _____

If you had an injury, how did it happen?: _____

_____

After the symptoms started, did they: ☐get worse quickly,☐get worse slowly, ☐stay the same, or ☐slowly improve

Now, is your problem getting: ☐Rapidly worse, ☐Slowly worse, ☐The same, ☐Slowly better, or ☐Rapidly better

What makes your problem **WORSE?** (**check ANY that apply**) ☐Activity, ☐Pressure, ☐Cold, ☐Sleeping,

☐Other _____

What makes your problem **BETTER?** (**check ANY that apply**)

☐Rest, ☐Splints or Braces, ☐Ice, ☐Heat, ☐Tylenol (Acetaminophen), ☐NSAID (Ibuprofen/Naproxen)

☐Other _____

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PAIN:

When your **pain is the worst**, circle the number corresponding to the intensity of your pain:

(0=no pain and 10 = the worst pain you can imagine)

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

When your **pain is the lowest**, circle the number corresponding to the intensity of your pain:

(0=no pain and 10 = the worst pain you can imagine)

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

What is your pain **right now**, here in the clinic?:

(0=no pain and 10 = the worst pain you can imagine)

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

QUALITY of the pain: Please check the description that best describes your pain:

☐Dull, ☐Sharp, ☐Aching, ☐Stabbing, ☐Heavy, ☐ Burning, ☐ Electrical/shooting, ☐ Other: _____

STIFFNESS: Circle the number corresponding to the **loss of mobility** (or stiffness) of your affected part:

(0=full normal motion and 10 = no motion at all)

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

WEAKNESS: Circle the number corresponding to the **loss of strength** of your hand, wrist, elbow, or shoulder:

(0=full normal strength and 10 = no strength at all)

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

NUMBNESS: Circle the number corresponding to the **loss of sensation** of your hand, wrist, elbow, or shoulder:

(0=full normal motion and 10 = no motion at all)

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

INFORMATION ABOUT YOU:

Marital status? ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Domestic partner

Do you have children? ☐Yes ☐No ☐If yes, how many? _____

Are you currently employed? ☐Employed ☐Retired ☐Homemaker ☐Student ☐Unemployed ☐Disabled

What is or was your occupation? _____

What sports do you enjoy? Hobbies? _____

If you are disabled, when did you last work? _____

Is this a work-related problem? ☐Yes ☐No

If yes, what is your Labor & Industries Claim# _____ or OWCP Claim # _____

Is a lawyer involved with this problem? ☐Yes ☐No

If so, give your lawyer's name: _____

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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 **OR** attach a separate list:

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

2. All other Medications *(please include vitamins and supplements)*	**Dose**	**Times per day**	**Reason for taking**

Social History

Tobacco Use Yes | Never | Quit | Passive

Packs/day 0.25 | 0.5 | 1 | 1.5 | 2 | 3 | _____ Years 0.5 | 1 | 2 | 3 | 4 | 5 | 10 | 15 | _____

Quit Date _____ Types Cigarettes | Pipe | Cigars | Snuff | Chew

Alcohol Use	Yes | No	**Drug Use**	Yes | No
Drinks/ Week	#_____ Glass(es) of wine #_____ Can(s) of beer #_____ Shot(s) of liquor	Use/Week	1 | 2 | 3 | 4 | 5 | 10 | 15 | _____
		Types	Amphetamines/Meth | Anabolic Steroids | Benzodiazepines | Cocaine | Hallucinogens | Marijuana | Opioids | IV | Inhaled | Intranasal | Oral

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Past Medical History

1. Have you had any of the following (please check all that apply):

No Medical Problems	Yes No	Cardiovascular Disease	Yes No	Headaches	Yes No	Osteoporosis	Yes No
Allergies	Yes No	Congestive Heart Failure	Yes No	Heart Attack	Yes No	Positive PPD	Yes No
Anemia	Yes No	COPD	Yes No	Heart Murmur	Yes No	Rheumatoid Arthritis	Yes No
Anxiety	Yes No	Depression	Yes No	Hepatitis	Yes No	Seizures	Yes No
Arthritis	Yes No	Diabetes Type 1	Yes No	HIV	Yes No	Stroke	Yes No
Asthma	Yes No	Diabetes Type 2	Yes No	Hypertension	Yes No	Substance Abuse	Yes No
Back Pain	Yes No	GERD	Yes No	Insomnia	Yes No	Thyroid Disorder	Yes No
Bleeding/Clotting Disorder	Yes No	Gastrointestinal Disorder	Yes No	Kidney Disease	Yes No	Tuberculosis	Yes No
Blood Transfusion	Yes No	Glaucoma	Yes No	Lipid Disorder	Yes No	Other (Please list below)	Yes No
Cancer	Yes No	GYN Problems	Yes No	Musculoskeletal	Yes No		

2. If you have or have had any other medical conditions not listed here, please specify.

Past Surgical History

1. Have you had any of the following (please check all that apply):

No Surgeries	Yes No	Gall Bladder	Yes No	Knee Surgery	Yes No	Spine Surgery	Yes No
Appendectomy	Yes No	Hand Surgery	Yes No	Mastectomy	Yes No	Tonsillectomy	Yes No
CABG	Yes No	Hernia Repair	Yes No	Neck Surgery	Yes No	Wrist Surgery	Yes No
Elbow Surgery	Yes No	Hip Surgery	Yes No	Shoulder Surgery	Yes No	Other	Yes No
Foot Surgery	Yes No	Hysterectomy	Yes No				

2. Have you had any other surgeries for the current problem? Yes No

Surgeries for This Problem and if they helped	**Surgeon**	**Year**

3. If you have had any other surgeries, please specify.

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Family History
Do you have any significant family history?, please specify:

Review of Systems Do you have or had any of the following Problems?			
	(Check any that apply)		**Comments**
General	☐weight gain ☐weight 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	

Physician Signature_____ Date_____