San Francisco Shoulder, Elbow and Hand Clinic		
Subject ID if applicable: __ __ __ - __ __ __ __	Study Shoulder: ❑ R ❑ L	**Patient Questionnaire**

Questionnaire completed on date of visit? ❍ Yes ❍ No

If NO: Date Completed (dd/mon/yyyy): __ __ / __ __ __ / __ __ __ __

Shoulder being assessed: ❍Left ❍Right

Weight: _____ ❍Kilograms (kg)
❍Pounds (lbs)

Health Status - Please check all of the following conditions that apply to you:

❑ Arthritis (rheumatoid and osteoarthritis)
❑ Osteoporosis
❑ Asthma
❑ Chronic obstructive pulmonary disease (COPD), acute respiratory distress syndrome, or emphysema
❑ Angina
❑ Congestive heart failure
❑ Heart attack (myocardial infarction
❑ Neurological disease (e.g., MS or Parkinson's disease)
❑ Stroke or transient ischemic attack (TIA)
❑ Peripheral vascular disease
❑ Diabetes types I or II
❑ Upper gastrointestinal disease (e.g., ulcer, hernia, reflux)
❑ Depression
❑ Anxiety or panic disorders
❑ Visual impairment (e.g., cataracts, glaucoma, macular degeneration)
❑ Hearing impairment (e.g., hard of hearing, with hearing aids)
❑ Degenerative disc disease (e.g., back disease, spinal stenosis, or severe chronic back pain)
❑ Bleeding disorder
❑ Chronic infection (e.g., MRSA, HIV, Hepatitis)
❑ Metal allergy – Type of metal: _____

Tobacco Use

❍None
❍Former Smoker
❍Current Smoker

Pain Management

Do you take narcotic pain medication (codeine or stronger) for your shoulder?
❍Yes ❍No

Treatment Coverage - How is your treatment being paid? (Check all that apply)

❑ Medicare
❑ Medicaid
❑ Other Government Insurance
❑ Private Insurance
❑ Self-pay / No insurance
❑ Worker's Compensation

Shoulder Pain / Function – Rest of form must be completed by patient

Select box if patient is unable to answer questions below: ❑

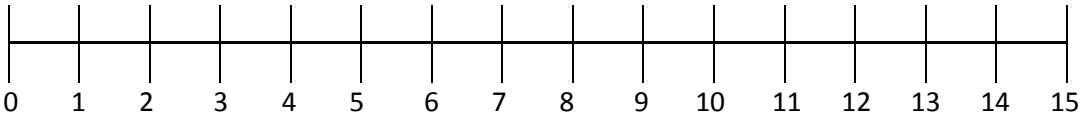
If box is selected above: Specify reason (e.g. traumatic fracture):_____

Pain:

Do you have pain in your shoulder (normal activities)?
❍ No ❍ Mild pain ❍ Moderate ❍ Severe or permanent

If "0" means no pain and "15" is the maximum pain you can experience, please indicate the level of pain in your shoulder. **(Indicate by marking the scale)**

No Pain **Maximum Pain**



Activities of daily living:

Is your night sleep disturbed by your shoulder?
❍ No ❍ Sometimes ❍ Yes

Is your occupation or daily living limited by your shoulder?
❍ No ❍ Mild ❍ Moderate ❍ Significant ❍ Severe

Are your leisure and recreational activities limited by your shoulder?
❍ No ❍ Mild ❍ Moderate ❍ Significant ❍ Severe

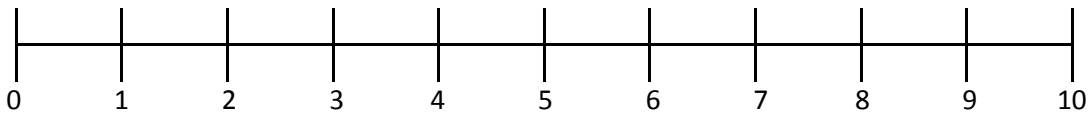
To which level can you use your arm for painless reasonable activities?
(check the <u>HIGHEST LEVEL</u> achievable)
❍Below Waist
❍Waist
❍Chest
❍Neck
❍Head
❍Above head

How satisfied are you with your shoulder?
❍ Very Satisfied
❍ Satisfied
❍ Dissatisfied
❍ Very Dissatisfied

How would you rate your shoulder today as a percentage of normal? _____
(0 to 100% scale with 100% being normal)

Pain Today:
How bad is your pain TODAY? **(Indicate by marking the scale)**

No pain **Pain as bad as it can be**



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Select a response that indicates your ability to do the activities listed below (with the shoulder being assessed).

	(Check one of these boxes for each activity)			
Activity:	Unable to do	Very Difficult to do	Somewhat difficult to do	Not difficult
Comb hair				
Do usual sport				
Do usual work				
Lift 10 pounds (4.5 Kg) above your shoulder				
Manage toileting				
Put on a coat				
Reach a high shelf				
Sleep on your side				
Throw a ball overhand				
Wash back or fasten bra in back				