Patient Label

UNIVERSITY *of* CALIFORNIA • IRVINE HEALTHCARE

CENTER FOR HAND & UPPER EXTREMITY SURGERY
SHOULDER & ELBOW NEW PATIENT FORM

HISTORY

Welcome and thank you for choosing the UC Irvine Center for Hand & Upper Extremity Surgery for your care. Please take the time to answer all questions that apply to your problems as completely as possible.

Visit Date (mm/dd/yy): ____/____/____ Name (Last, First): ____________________

Date of birth (mm/dd/yy): ____/____/____ Age:______ Sex: ☐ Male ☐ Female

Who referred you to this office?

☐ Referring Doctor:______________ Address:______________ Phone:__________

☐ Primary Physician:______________ Address:______________ Phone:__________

☐ Self Referral

A. Symptoms & Pain Assessment

1. Hand Dominance: ☐ Right ☐ Left ☐ Both
2. Upper Extremity affected: ☐ Right ☐ Left ☐ Both

   Which part of your arm is bothering you? (Please check ✓ in the box):

   ☐ Shoulder ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand

   ☐ Thumb ☐ Index finger ☐ Middle finger ☐ Ring finger ☐ Small finger
3. Chief Complaint: ______________________________
4. How long have you had these symptoms? ______Days ______Weeks ______Months ______Years
5. Describe the quality of your symptoms (Please check ✓ in the box):

   ☐ Pain ☐ Weakness ☐ Deformity ☐ Instability ☐ Abnormal motion ☐ Abnormal sensation

   ☐ Mass ☐ Swelling ☐ Other ______________________
6. How often do you experience these symptoms?

   ☐ Constant ☐ Intermittent ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ______________
7. How did your symptoms start? ☐ Gradually ☐ Suddenly

   What date did your symptoms start?______________
8. Was there any injury/event that caused your symptoms?

   ☐ No ☐ Yes - Date of Injury (mm/dd/yy): ____/____/____

   Please describe how you were injured: ______________________________

   ____

a. Legal actions pending? ☐ No ☐ Yes
b. Work related?
☐ No
☐ Yes - Employer at time of injury: ______________________
Job Title: ______________________
Worker's Compensation? ☐ No ☐ Yes - Name of your attorney: ______________________

9. Any prior hand or upper extremity injury/pain before the event above?
☐ No ☐ Yes - What type? (Please describe) ______________________

10. Since your symptoms started, have they been getting: ☐ Better ☐ Worse ☐ Staying the same

11. What makes your symptoms better? (Please describe)

____

____

12. What makes your symptoms worse? (Please describe)

____

____

B. Previous Treatment & Evaluation

1. What diagnostic tests have you had for this problem?
☐ X-ray ☐ MRI ☐ CT ☐ EMG/NCS ☐ Blood tests ☐ MR Arthrogram ☐ Other ______________________

2. Please check ✓ any of the following if you have tried for your symptom or discomfort:
☐ Surgery ☐ Steroid injections ☐ Physical therapy ☐ Massage ☐ Splinting
☐ Anti-inflammatory medications ☐ Other ______________________

Which treatment has been the **best** treatment?

____

C. Medical/Surgical History

1. Please list other medical problems (Please check ✓ in the box):

☐ High blood pressure	☐ Arthritis	☐ Diabetes	☐ Heart disease - type: ________
☐ Stroke	☐ Osteoporosis	☐ High Cholesterol	☐ Cancer - type: ________
☐ Thyroid	☐ Asthma	☐ Stomach Ulcer	☐ Kidney stones
☐ Blood clots in leg	☐ Blood clots in lungs	☐ Depression	☐ AIDS/HIV

☐ Other ______________________

2. Have you ever had **<u>hand or upper extremity surgery</u>** in the past?
☐ No
☐ Yes - Type of hand or upper extremity surgery:

______________________ Date: ____________

______________________ Date: ____________

______________________ Date: ____________

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3. Please list other surgeries:

_______________ Date: _______________

_______________ Date: _______________

_______________ Date: _______________

D. Family Medical History (Please check ✓ in the box):

☐ Arthritis ☐ Bone Disease ☐ Heart Disease ☐ Diabetes ☐ Cancer

Mother	Age: ______	☐ Healthy	☐ Deceased due to: ______
Father	Age: ______	☐ Healthy	☐ Deceased due to: ______
Brother/Sister	Age: ______	☐ Healthy	☐ Deceased due to: ______
	Age: ______	☐ Healthy	☐ Deceased due to: ______

E. Social History (Please check ✓ in the box):

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you drink alcohol? ☐ No ☐ Yes If Yes, how much? ______

Do you smoke? ☐ No ☐ Yes If Yes, how much? ______

Do you use recreational substances? ☐ No ☐ Yes If Yes, Type and Frequency: ______

Are you currently working?

☐ No

☐ Yes - Employer: ______ Job Title: ______

Length of time on job: ______ hours/day ______ days/week

Movements required for your job (Please check ✓ in the box):

☐ pushing ☐ pulling ☐ grasping ☐ lifting _____ pounds

☐ reaching above shoulders ☐ repetitive wrist/hand movements

Machines used: ______

Are you able to perform your usual duties? ☐ No ☐ Yes

F. Review of Systems

(Please check ✓ in the box if you **currently** have any problems related to the following systems):

Skin	**Neurological**	**Eyes**	**Bone/Joint/Muscles**
☐ Skin rash	☐ Headache	☐ Visual loss	☐ Muscle wasting
☐ Easy bruising/bleeding	☐ Migraine	☐ Double vision	☐ Muscle cramping
☐ Abnormal hair loss	☐ Seizure	☐ Glaucoma	☐ Joint pain
	☐ Paralysis	☐ Glasses/Contacts	

F. **Review of Systems** (Continued)
(Please check ✓ in the box if you **currently** have any problems related to the following systems):

Ears/Nose
- ☐ Deafness
- ☐ Hoarseness
- ☐ Vertigo/dizziness
- ☐ Sinusitis

Genitourinary
- ☐ Blood in urine
- ☐ Impotence
- ☐ Painful urination
- ☐ Kidney stones
- ☐ Incontinence

Mental Status
- ☐ Hallucination
- ☐ Nervous breakdown
- ☐ Depression
- ☐ Sleep disturbance
- ☐ Suicidal thoughts

Respiratory
- ☐ Shortness of breath
- ☐ Asthma/Bronchitis
- ☐ Cough
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Emphysema / COPD

Gastrointestinal
- ☐ Appetite changes
- ☐ Jaundice
- ☐ Irritable bowels
- ☐ Nausea/Vomiting

Endocrine
- ☐ Goiter
- ☐ Heat/Cold intolerance
- ☐ Increased thirst

Cardiovascular
- ☐ Palpitations
- ☐ Chest pains
- ☐ Leg swelling
- ☐ Arrhythmia

Constitutional
- ☐ Fever/chills
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue

Blood System
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Bruising

MEDICATION

1. **Do you have any Allergies to Medications, Food or Latex?**

☐ No

☐ Yes - Allergies:______________________ Reaction: ______________________

Allergies:______________________ Reaction: ______________________

Allergies:______________________ Reaction: ______________________

2. **Current Medications:**

☐ None

☐ Yes, listed below:

Medications	Dose	Route	Frequency	Time & Date Last Taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

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ASES (AMERICAN SHOULDER AND ELBOW SURGEONS) SHOULDER EVALUATION

PATIENT SELF-EVALUATION		
Are you having pain in your shoulder? *(circle correct answer)*	Yes	No
Mark where your pain is on this diagram		
Do you have pain in your shoulder at night?	Yes	No
Do you take pain medication (aspirin, Advil, Tylenol, etc.)?	Yes	No
Do you take narcotic pain medication (codeine or stronger)?	Yes	No
How many pills do you take each day (average)?	________ pills	
How bad is your pain today (mark line)? 0 |___|___|___|___|___|___|___|___|___|___| 10 No pain at all — 5 — Pain as bad as it can be		
Does your shoulder feel unstable (as if it is going to be dislocated?)	Yes	No
How unstable is your shoulder (mark line)? 0 |___|___|___|___|___|___|___|___|___|___| 10 Very stable — 5 — Very unstable		

ASES (American Shoulder and Elbow Surgeons) Shoulder Evaluation (Continued)

Circle the number in the box that indicates your ability to do the following activities:
0 = Unable to do; 1 = Very difficult; 2 = Somewhat difficult; 3 = Not difficult

ACTIVITY	RIGHT ARM	LEFT ARM
1. Put on a coat	0 1 2 3	0 1 2 3
2. Sleep on your painful or affected side	0 1 2 3	0 1 2 3
3. Wash back/do up bra in back	0 1 2 3	0 1 2 3
4. Manage toiletting	0 1 2 3	0 1 2 3
5. Comb Hair	0 1 2 3	0 1 2 3
6. Reach a high shelf	0 1 2 3	0 1 2 3
7. Lift 10 lbs. above shoulder	0 1 2 3	0 1 2 3
8. Throw a ball overhand	0 1 2 3	0 1 2 3
9. Do usual work - List:	0 1 2 3	0 1 2 3
10. Do usual sport - List:	0 1 2 3	0 1 2 3

Patient's Signature: ______________________ **Date:** ____________ **Time:** __________

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ASES (American Shoulder and Elbow Surgeons) Shoulder Evaluation (Continued)

Note: Physician use only. (To be completed by the physician).

PHYSICIAN ASSESSMENT				
RANGE OF MOTION	**RIGHT**		**LEFT**	
Total shoulder motion Goniometer preferred	Active	Passive	Active	Passive
Forward elevation (Maximum arm-trunk angle)				
External rotation (Arm comfortable at side)				
External rotation (Arm at 90° abduction)				
Internal rotation (Highest posterior anatomy reached with thumb)				
Cross-body abduction (Antecubital fossa to opposite acromion)				

SIGNS 0 = none; 1 = mild; 2 = moderate; 3 = severe			
SIGN		**RIGHT**	**LEFT**
Supraspinatus/greater tuberosity tenderness		0 1 2 3	0 1 2 3
AC joint tenderness		0 1 2 3	0 1 2 3
Biceps tendon tenderness (or rupture)		0 1 2 3	0 1 2 3
Other tenderness - List		0 1 2 3	0 1 2 3
Impingement I (Passive toward elevation in slight internal rotation)		Y N	Y N
Impingement II (Passive internal rotation with 90° flexion)		Y N	Y N
Impingement III (90° active abduction - classic painful arc)		Y N	Y N
Subacromial crepitus		Y N	Y N
Scars - location		Y N	Y N
Atrophy - location		Y N	Y N
Deformity: describe		Y N	Y N

STRENGTH

(record MRC grade)

0 = no contraction; 1 = flicker; 2 = movement with gravity eliminated
3 = movement against gravity; 4 = movement against some resistance; 5 = normal power.

	RIGHT	LEFT
Testing affected by pain?	Y N	Y N
Forward elevation	0 1 2 3 4 5	0 1 2 3 4 5
Abduction	0 1 2 3 4 5	0 1 2 3 4 5
External rotation (Arm comfortably at side)	0 1 2 3 4 5	0 1 2 3 4 5
Internal rotation (Arm comfortably at side)	0 1 2 3 4 5	0 1 2 3 4 5

INSTABILITY

0 = none; 1 = mild (0 - 1 cm translation)
2 = moderate (1 - 2 cm translation or translates to glenoid rim)
3 = movement against gravity (> 2 cm translation or over rim of glenoid)

	RIGHT	LEFT
Anterior translation	0 1 2 3	0 1 2 3
Posterior translation	0 1 2 3	0 1 2 3
Inferior translation (sulcus sign)	0 1 2 3	0 1 2 3
Anterior apprehension	0 1 2 3	0 1 2 3
Reproduces symptoms?	Y N	Y N
Voluntary instability?	Y N	Y N
Relocation test positive?	Y N	Y N
Generalized ligamentous laxity?	Y N	

Other physical findings:

MD Signature:______________________________ **Date:**____________ **Time:**__________

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.