Shoulder / Elbow Questionnaire

Hand Dominance (Please circle): Right / Left / Ambidextrous

When did your problem begin?: ____

If you have had an injury, please describe it in detail:

____

____

What is the main problem with your arm? (Please circle all relevant problems):
Pain / Instability / Loss of Function / Weakness / Stiffness / All

If you have pain, please circle:

- **Type:** ache / sharp / burning
- **Duration:** constant / intermittent / on certain movements
- **Severity:** no pain 0 1 2 3 4 5 6 7 8 9 10 severe pain
- **Interferes with sleep?** Yes / No
- **Do you take pain relief?** Yes (___ tabs / day) No

Do you have any difficulty with: (please circle all relevant problems):
Overhead tasks / getting dressed / hobbies eg gardening / driving / doing up bra or reaching for the back pocket / playing sport

What treatments have you had so far?

Treatment	Sessions	Benefit
Physiotherapy		worse / none / better
Anti-inflammatories		worse / none / better
Steroid (cortisone) injections		worse / none / better
Surgery		worse / none / better
Other		worse / none / better

Medical History Form

Please circle if you have any of the medical conditions listed:

Angina (chest pain) / Heart Attack / Pacemaker / Heart Valve Surgery	Diabetes (high blood sugar levels) Treated with diet / tablets / insulin
Stroke	Hepatitis (liver disease)
Hypertension (high blood pressure)	Bleeding disorder
Seizures / Epilepsy	Cancer
Renal disease (kidney disease)	DVT (blood clots in the leg)
Asthma / Bronchitis (lung problems)	PE (blood clots in the lung)
Other:	

List any operations you have had in the past:

Did you suffer any major complications after previous operations? If so, what?

List any medications you are currently taking:

Circle if you take: Warfarin / Pradaxa / Steroids / Aspirin / any blood thinners

Do you have any allergies? What happens?

Do you smoke?: Yes / No How many per day? _________ When did you quit?_________________

Do you drink any alcohol?: Yes / No How many drinks per day? _________________________