Sydney Shoulder Specialists

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New Patient Details

Elbow Form

Your Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr ☐ Other: _____

First (given) Names*: _____ Surname*: _____

*__must__ be the same as they appear on your Medicare card if you have one

Preferred Name (if any): _____ **Date of Birth**: _____/_____/_____ Age: ____ Gender: Male ☐ Female ☐

Address: _____ Mobile Ph: _____

Suburb: _____ Home Ph: _____ Work Ph: _____

State: _____ Postcode: _____ Email: _____@_____

Account to be sent to (ie parent's name if patient is a child): _____

Next of kin: _____ **(required by law)** Next of kin's mobile number: _____

What is your next of kin's relationship to you?: _____

Medicare Number: _____ Your Ref No on the card: _____ Expiry date: ____/____

Private Health Fund: _____ Membership No: _____

Please tick if you have a: Pension card ☐ Health Care card ☐ Gold DVA card ☐ or a White DVA card ☐

Card number for the above: _____ What is the card's expiry date?: ____/____/____

Name of referring doctor: _____ Is this doctor is a: GP ☐ or a Specialist ☐?

The name of your usual GP (general practitioner) if different from above: _____

GP's address: _____ Phone: _____

Physiotherapist: _____ Phone: _____

Physiotherapist's address: _____

Are you retired? Yes ☐ Semi-retired ☐ No ☐ What is (or was) your occupation? _____

Competitive Sports you play: _____ Other sports: _____

Will your consultation be related to a claim for Workers Compensation? YES ☐ NO ☐? *If you answered **YES**, please complete:*

Workers Compensation Claims ONLY

Date of Injury: ____/____/____ Employer's name (company): _____ Phone: _____

Employer's address: _____ Fax or email: _____

Insurance Company: _____ Claim Number (if known): _____

Insurance Company's address: _____ _____ Fax or email: _____

Case Manager's name: _____ Phone (direct number): _____

Case Manager's email address: _____@_____

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Medication, Allergy and Surgical History

Are you taking **blood thinners?** No☐ Yes☐ - *if yes, which?* Warfarin☐ Plavix☐ Aspirin☐ other☐: _____

Do you regularly take **pain** medications? No☐ Yes☐ – *if yes which ones?* _____

Do you take any **herbal** medications? No☐ Yes☐ – *if yes which ones?* _____

Are there any other current or regular medications that you take? _____

Do you drink **alcohol**? No☐ Yes☐ – *if yes, how many days per week usually?* ____ *& how many drinks on those days usually?* ___

Do you have any **allergies to DRUGS?** No☐ Unknown☐ Yes☐ - *if yes, which drugs?*_____

What allergic reaction to drugs do you have? Rash☐ Shortness of Breath☐ Swelling☐ Anaphylaxis☐ other☐: _____

What **else (apart from drugs)** are you **allergic** to? (eg latex, food, dust mites, cats, dogs, grass)_____

What allergic reaction to these things do you have? Rash☐ Shortness of Breath☐ Swelling☐ Anaphylaxis☐ other☐: _____

Have you had **any previous surgery (not just upper limb)**? No☐ Yes☐ *If yes - what type and when?*_____

_____

Have you ever had **complications** after surgery? No☐ Yes☐ *If yes - what complications?*_____

_____

Medical History

Arthritis
- *Osteoarthritis?* No☐ Yes☐
- *Rheumatoid Arthritis?* No☐ Yes☐

Diabetes? No☐ Yes☐
- *If Yes, how is it controlled?* by Tablet☐ Insulin☐ Diet☐

Epilepsy? No☐ Yes☐
- *If Yes, do you take medication?* No☐ Yes☐

Liver Disease
- *Hepatitis B?* No☐ Yes☐
- *Hepatitis C?* No☐ Yes☐

Stroke(s)? No☐ Yes☐

Past Blood Transfusions? No☐ Yes☐

HIV / AIDS? No☐ Yes☐

Kidney Conditions? No☐ Yes☐

Gastric Problems
- *Indigestion / Reflux?* No☐ Yes☐
- *Stomach Ulcers?* No☐ Yes☐

Venous Conditions
- *DVT (Thrombosis)?* No☐ Yes☐
- *Varicose Veins?* No☐ Yes☐

Thyroid Conditions
- *Hyper-active thyroid?* No☐ Yes☐
- *Hypo-active thyroid?* No☐ Yes☐

Cardiac Problems
- *Heart Attack?* No☐ Yes☐
- *High Blood Pressure?* No☐ Yes☐
- *Low Blood Pressure?* No☐ Yes☐

*Other?:*_____

Lung Conditions
- *Asthma?* No☐ Yes☐
- *Emphysema?* No☐ Yes☐
- *Sleep Apnoea?* No☐ Yes☐
- *Pulmonary Embolus?* No☐ Yes☐
- *Are you a smoker?* Never☐ Quit☐ Yes☐

Cancer
- *Breast?* No☐ Yes☐
- *Mastectomy?* No☐ Yes☐
- *Elbow or Shoulder Region?* No☐ Yes☐

*Other?*_____

Any problems with other joints? No☐ Yes☐
- *If yes, which?* _____

Elbow Symptoms

Which elbow is it? Left☐ Right☐ *or* both elbows☐

Hand dominance? Left☐ Right☐ *or* ambidextrous☐

When did symptoms start? ____/____/____ (*approx is OK*)

Did they start **suddenly**? ☐ *or* develop gradually? ☐

Were they from an **injury**? No☐ Yes☐ *or* unsure☐

If Yes, when was the injury? ____/____/____ (*approx is OK*)

What **type of injury**? sports☐ a fall☐ car accident☐
bicycle accident☐ motorbike accident☐
work accident☐ or a repetitive injury☐
or another accident☐: _____

Do you have now or have you had any elbow:
- *Stiffness?* No☐ Yes☐

Do you have now or have you had any elbow:
- *Weakness?* No☐ Yes☐
- *Dislocations?* No☐ Yes☐
  - ↘ *If* Yes, *how many have you had?* _____

To treat your symptoms have you had any:
- *Physiotherapy?* No☐ Yes☐
- *Injections?* No☐ Yes☐
  - ↘ *If* Yes, *how many have you had?* _____
- *Surgery?* No☐ Yes☐
  - ↘ *If* Yes, *when?* _____

Type/Name? _____

Other treatments? No☐ Yes☐
- ↘ *If* Yes, *what?* _____

The Oxford Elbow Score

Tick the box next to the answer that best fits. Please only give one answer per question.

1 During the past 4 weeks. . .

Have you had difficulty lifting things in your home, such as putting out the rubbish, because of your elbow problem?

No difficulty ☐ A little difficulty ☐ Moderate difficulty ☐ Extreme difficulty ☐ Impossible to do ☐

2 During the past 4 weeks. . .

Have you had difficulty carrying bags of shopping, because of your elbow problem?

No difficulty ☐ A little difficulty ☐ Moderate difficulty ☐ Extreme difficulty ☐ Impossible to do ☐

3 During the past 4 weeks. . .

Have you had any difficulty washing yourself all over, because of your elbow problem?

No difficulty ☐ A little difficulty ☐ Moderate difficulty ☐ Extreme difficulty ☐ Impossible to do ☐

4 During the past 4 weeks. . .

Have you had any difficulty dressing yourself, because of your elbow problem?

No difficulty ☐ A little difficulty ☐ Moderate difficulty ☐ Extreme difficulty ☐ Impossible to do ☐

5 During the past 4 weeks. . .

Have you felt that your elbow problem is "controlling your life"?

Not at all ☐ A little of the time ☐ Some of the time ☐ Most of the time ☐ All of the time ☐

6 During the past 4 weeks. . .

How much has your elbow problem been "on your mind"?

Not at all ☐ A little of the time ☐ Some of the time ☐ Most of the time ☐ All of the time ☐

7 During the past 4 weeks. . .

Have you been troubled by pain from your elbow in bed at night?

Not at all ☐ 1 or 2 nights ☐ Some of the time ☐ Most of the time ☐ Every night ☐

8 During the past 4 weeks. . .

How often has your elbow interfered with your sleeping?

Not at all ☐ A little of the time ☐ Some of the time ☐ Most of the time ☐ All of the time ☐

9 During the past 4 weeks. . .

How much has your elbow problem interfered with your usual work or everyday activities?

Not at all ☐ A little bit ☐ Moderately ☐ Greatly ☐ Totally ☐

10 During the past 4 weeks. . .

Has your elbow problem limited your ability to take part in leisure activities that you enjoy doing?

Not at all ☐ A little of the time ☐ Some of the time ☐ Most of the time ☐ All of the time ☐

11 During the past 4 weeks. . .

How would you describe the worst pain you have from your elbow?

No pain ☐ Mild pain ☐ Moderate pain ☐ Severe pain ☐ Unbearable ☐

12 During the past 4 weeks. . .

How would you describe the pain you usually have from your elbow?

No pain ☐ Mild pain ☐ Moderate pain ☐ Severe pain ☐ Unbearable ☐

The Mayo Elbow Performance Score

PAIN

How bad is the pain in your elbow?

I don't have any pain ☐ Mild ☐ Moderate ☐ Severe ☐

MOTION

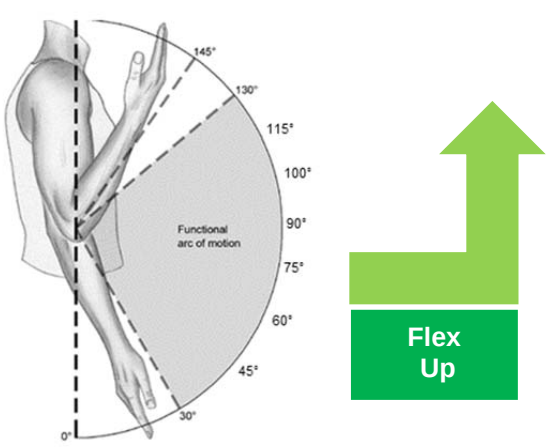
Can you please show us how far you can FLEX your arm?

To flex your arm let it rest by your side then raise it with palm facing up (like in the picture) towards your shoulder but don't raise your elbow. Follow the direction of the arrow below.

Do this as comfortably as you can.

Please compare your arm position with the picture and write the position on the semi-circle (eg 130°)

closest to what you can FLEX to: _____

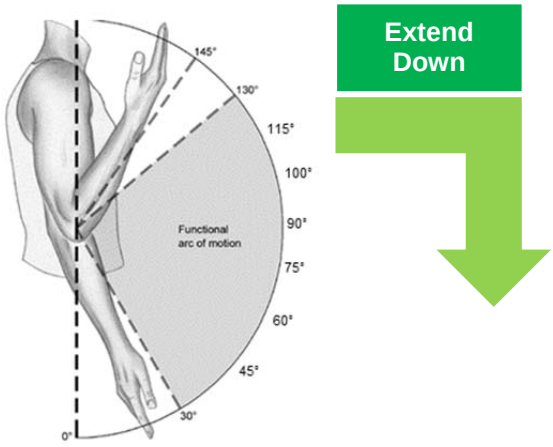


And also, can you please show us how far you can EXTEND your arm?
After you have raised your arm to flex it, try to lower it down towards the floor. Follow the direction of the arrow below.

Do this as comfortably as you can.

Please compare your arm position with the picture and write the position on the semi-circle (eg 45°)

closest to what you can EXTEND to: _____



INSTABILITY

How stable does your elbow feel?

Stable ☐ Moderately unstable ☐ Extremely unstable ☐

FUNCTION

Which of these things can you currently do with the sore elbow (arm)? *(please tick ALL that you can do)*

Comb hair ☐ Eat ☐ Perform hygiene tasks ☐ Put on a shirt ☐ Put on a shoe ☐

The American Shoulder & Elbow Society Rating Scale

1 If 0 = no pain and 10 = the worst pain, how bad is your pain **today** out of 10? _____

2 Tick the box next to the number that indicates your ability to do the activity **normally** (i.e. not just today)

NOTE: 0 = unable to do and 3 = easy to do

	LEFT Elbow *(we need both for comparison)*				**RIGHT Elbow**			
	Unable ↓	Very difficult ↓	A bit difficult ↓	Easy to do ↓	Unable ↓	Very difficult ↓	A bit difficult ↓	Easy to do ↓
Put on a coat	0 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
Sleep on your side	0 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
Wash your back or do your bra up	0 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
Manage toileting	0 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
Comb hair (or if bald/other handed, do that action)	0 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
Reach a high shelf	0 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
Lift 5kgs or 10lbs above the shoulder	0 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
Throw a ball overhand	0 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
Do your usual work or activities	0 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
Do your usual sport or hobby/leisure activity	0 ☐	1 ☐	2 ☐	3 ☐	0 ☐	1 ☐	2 ☐	3 ☐
	Unable ↑	Very difficult ↑	A bit difficult ↑	Easy to do ↑	Unable ↑	Very difficult ↑	A bit difficult ↑	Easy to do ↑

3 Are you having pain in your elbow? Yes ☐ No ☐

4 Do you have pain in your elbow at night? Yes ☐ No ☐

5 Do you take pain medication (eg Panadol, Nurofen, Aspirin etc?) Yes ☐ No ☐

6 Do you take narcotic medication (eg Panadeine, Nurofen Plus or stronger?) Yes ☐ No ☐

7 How many tablets would you take each day (on average) **just for your elbow**? ____ tablets

8 Does your elbow feel unstable (i.e. as if it is going to dislocate)? Yes ☐ No ☐

9 If 0 = not at all and 10 = unstable, how unstable does your elbow feel **today** out of 10? ____

Consent to Collect Patient Information – Privacy Act 2002

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. **NB:** please refer to our practice *Privacy Policy* online at www.sydneyshoulder.com.au or ask for a copy.

We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
3. Disclosure to others involved in your care, including doctors and specialists outside this medical practice as advised by you.

I understand the reasons why my information must be collected.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purpose other than the above, my consent will be sought.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

ADDENDUM

I also understand that I seek the care of Dr Cass for my medical management and that it is a policy of the practice that Dr Cass does not undertake examinations and/or reports for the purpose of Medico-Legal matters or Third Party claims.

Signed (*digital signature not required*): _____ **Today's Date:** _____/_____/_____

Patient Name (*typed or printed*): _____ **Thank you for completing this form**

Please now save the form then attach to an email and send to cassadmin@sydneyshoulder.com.au