



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: _____

*While Sydney Shoulder Specialists take every precaution to ensure files are safe to download they cannot accept liability for any interference with or damage to your computer system, software or data occurring in connection with or relating to this form or its use. Your own adequate computer system, software and data protection are essential.

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? _____



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

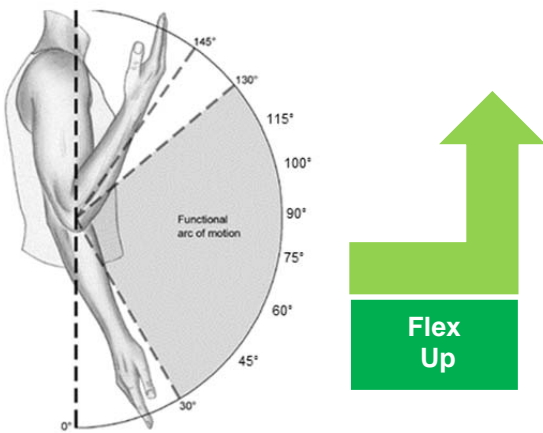
Can you please show us how far you can FLEX your arm?

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: _____



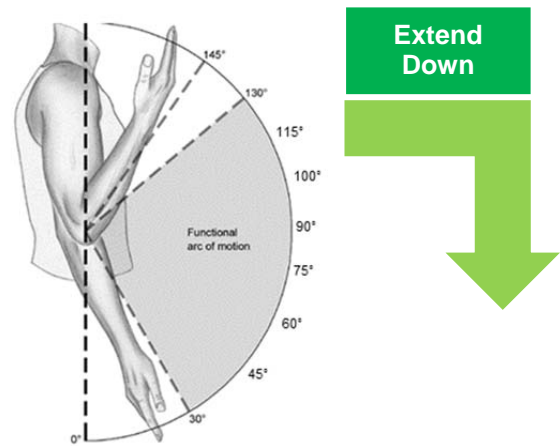
And also, can you please show us how far you can EXTEND your arm?

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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Sleep on your side	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Wash your back or do your bra up	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Manage toileting	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Comb hair (or if bald/other handed, do that action)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Reach a high shelf	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Lift 5kgs or rolbs above the shoulder	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Throw a ball overhand	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Do your usual work or activities	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Do your usual sport or hobby/leisure activity	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
	↑ 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 <input type="checkbox"/>	No <input type="checkbox"/>		
4 Do you have pain in your elbow at night?						Yes <input type="checkbox"/>	No <input type="checkbox"/>		
5 Do you take pain medication (eg Panadol, Nurofen, Aspirin etc?)						Yes <input type="checkbox"/>	No <input type="checkbox"/>		
6 Do you take narcotic medication (eg Panadeine, Nurofen Plus or stronger?)						Yes <input type="checkbox"/>	No <input type="checkbox"/>		
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 <input type="checkbox"/>	No <input type="checkbox"/>		
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

