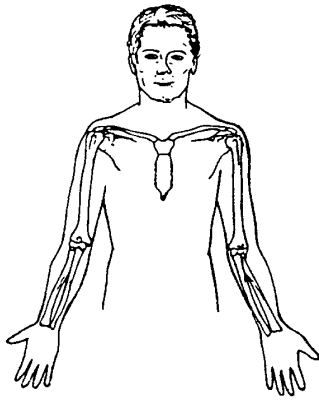
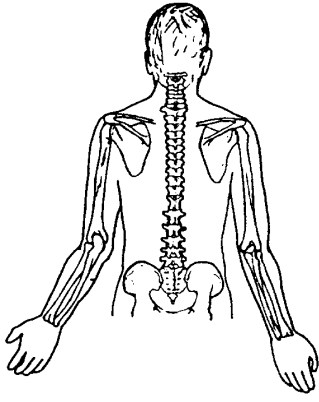


**SHOULDER ASSESSMENT FORM (Pre-Op)**  
AMERICAN SHOULDER AND ELBOW SURGEONS

Name:		Date
Age:	<input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed	Sex:    M    F
Diagnosis:		Initial Assess?   Y   N Follow-up:    M    Y
Procedure/Date:		Pharmacy name: Pharmacy #:

**PATIENT SELF-EVALUATION**

Are you having pain in your shoulder? (circle correct answer)	Yes	No
<p>Mark where your pain is on this diagram:</p> <div style="display: flex; justify-content: space-around; align-items: center;">   </div>		
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	
<p>How bad is your pain today (mark line)?</p> <p align="center">0   _____   10</p> <p>No pain at all <span style="float: right;">Pain as bad as it can be</span></p>		
Does your shoulder feel unstable (as if it is going to dislocate?)	Yes	No
<p>How unstable is your shoulder (mark line)?</p> <p align="center">0   _____   10</p> <p>Very stable <span style="float: right;">Very <u>un</u>stable</span></p>		

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 = **Normal**

ACTIVITY	RIGHT ARM	LEFT ARM
1. Use Back Pocket	0 1 2 3	0 1 2 3
2. Use Toilet Tissue	0 1 2 3	0 1 2 3
3. Wash Opposite Armpit	0 1 2 3	0 1 2 3
4. Eat with Utensil	0 1 2 3	0 1 2 3
5. Comb/Wash Hair	0 1 2 3	0 1 2 3
6. Dress with Hand	0 1 2 3	0 1 2 3
7. Sleep On Affected Arm	0 1 2 3	0 1 2 3
8. Lifting	0 1 2 3	0 1 2 3
9. Work Activities	0 1 2 3	0 1 2 3
10. Participation in Sports	0 1 2 3	0 1 2 3

**Patient Assessment:**

**Pain**

On the following scale of 0-10, please mark the average amount of pain you experience in your shoulder on a daily basis.

0 = no pain at all

10 = the worst pain imaginable



No pain at all

5

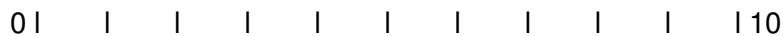
Pain as bad as it can be

**Function**

On the following scale of 0-10, please mark what you consider to be the current overall function of your shoulder.

0 = my shoulder is useless

10 = my shoulder is normal



Useless

5

Normal

## SF-36 Questionnaire

**Instructions:** Thank you in advance for taking the time to fill this questionnaire out. This questionnaire is about **YOU** and how **YOU** feel your physical health affects other aspects of your life. There are no right or wrong answers. Please read each question carefully, and answer as honestly as you can. Circle the **ONE** response which **YOU** feel represents **YOUR** feelings.

1. In general, would you say your health is:

- Excellent..... 1
- Very Good..... 2
- Good..... 3
- Fair..... 4
- Poor..... 5

2. Compared to one year ago, how would you rate your health in general now?

- Much better now than 1 year ago..... 1
- Somewhat better now than 1 year ago..... 2
- About the same as 1 year ago..... 3
- Somewhat worse now than 1 year ago..... 4
- Much worse now than 1 year ago..... 5

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes Limited a lot	Yes Limited a little	No Not limited at all
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking more than one mile	1	2	3
h. Walking several blocks	1	2	3
i. Walking one block	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

- a. Cut down the amount of time you spent on work or other activities <sup>1</sup> Yes      <sup>2</sup> No
- b. Accomplished less than you would like <sup>1</sup> Yes      <sup>2</sup> No
- c. Were limited in the kind of work or other activities <sup>1</sup> Yes      <sup>2</sup> No
- d. Had difficulty performing the work or other activities (for example, it took extra effort) <sup>1</sup> Yes      <sup>2</sup> No

5. During the past 4 weeks have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

- a. Cut down on the amount of time you spent on work or other activities <sup>1</sup> Yes      <sup>2</sup> No
- b. Accomplished less than you would like <sup>1</sup> Yes      <sup>2</sup> No
- c. Didn't do work or other activities as carefully as usual <sup>1</sup> Yes      <sup>2</sup> No

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- <sup>1</sup> Not at all      <sup>2</sup> Slightly      <sup>3</sup> Moderately      <sup>4</sup> Quite a bit      <sup>5</sup> Extremely

7. How much bodily pain have you had during the past 4 weeks?

- <sup>1</sup> None      <sup>2</sup> Very Mild      <sup>3</sup> Mild      <sup>4</sup> Moderate      <sup>5</sup> Severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- <sup>1</sup> Not at all      <sup>2</sup> A little bit      <sup>3</sup> Moderately      <sup>4</sup> Quite a bit      <sup>5</sup> Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling:

How much of the time during the past 4 weeks

	All of Of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of pep?	1	2	3	4	5
b. Have you been very nervous?	1	2	3	4	5
c. Have you felt down in the dumps?	1	2	3	4	5
d. Have you felt calm and peaceful?	1	2	3	4	5
e. Did you have a lot of energy?	1	2	3	4	5
f. Have you felt downhearted and blue?	1	2	3	4	5
g. Did you feel worn out?	1	2	3	4	5
h. Have you been happy?	1	2	3	4	5
i. Do you feel tired?	1	2	3	4	5

10. During the past 4 weeks, how much of your time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)

<sup>1</sup> All of the time    <sup>2</sup> Most of the time    <sup>3</sup> Some of the time    <sup>4</sup> A little of the time    <sup>5</sup> None of the time

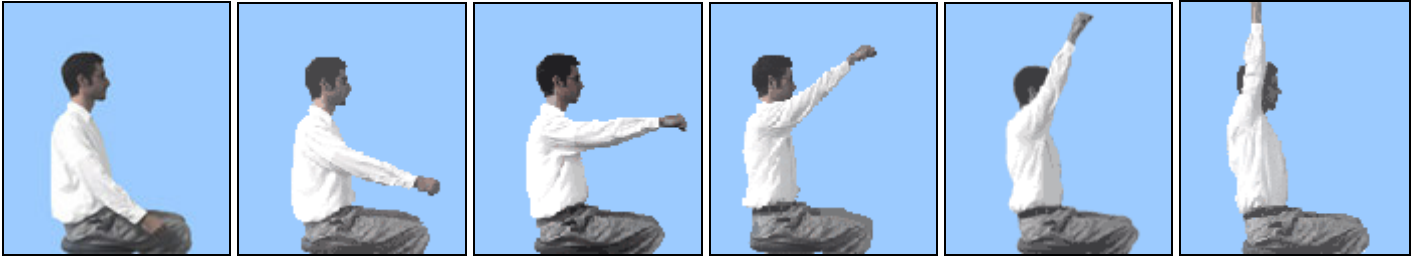
11. How true or false is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

**Answer each question below by checking “Yes” or “No”:**

	Yes	No
1. Is your shoulder comfortable with your arm at rest by your side?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your shoulder allow you to sleep comfortably?	<input type="checkbox"/>	<input type="checkbox"/>
3. Can you reach the small of your back to tuck in your shirt with your hand?	<input type="checkbox"/>	<input type="checkbox"/>
4. Can you place your hand behind your head with the elbow straight out to the side?	<input type="checkbox"/>	<input type="checkbox"/>
5. Can you place a coin on the shelf at the level of your shoulder without bending your elbow?	<input type="checkbox"/>	<input type="checkbox"/>
6. Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?	<input type="checkbox"/>	<input type="checkbox"/>
7. Can you lift eight pounds (a full gallon container) to the level of your shoulder without bending your elbow?	<input type="checkbox"/>	<input type="checkbox"/>
8. Can you carry twenty pounds at your side with the affected extremity?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you think you can toss a softball under-hand twenty yards with the affected extremity?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you think you can toss a softball over-hand twenty yards with the affected extremity?	<input type="checkbox"/>	<input type="checkbox"/>
11. Can you wash the back of your opposite shoulder with the affected extremity?	<input type="checkbox"/>	<input type="checkbox"/>
12. Would your shoulder allow you to work full-time at your regular job?	<input type="checkbox"/>	<input type="checkbox"/>

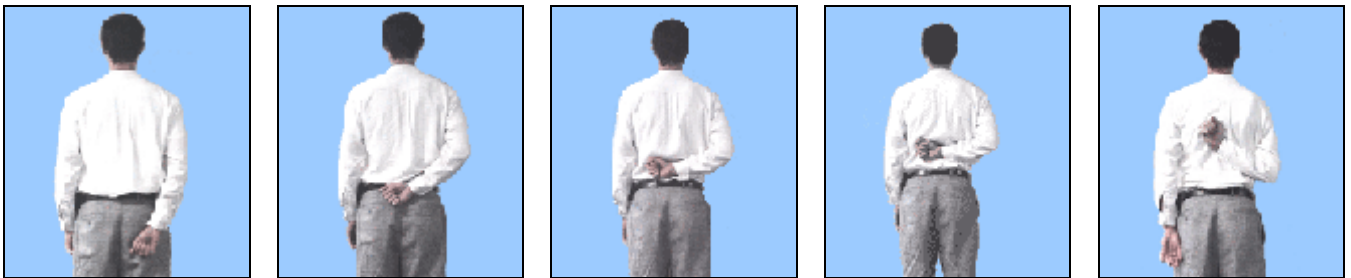
**Range of Motion:** Please mark which pictures you are capable of performing.



[ ] [ ] [ ] [ ] [ ] [ ]



[ ] [ ] [ ] [ ] [ ] [ ]



[ ] [ ] [ ] [ ] [ ]

How would you rate your personal satisfaction with your surgery?

Excellent                  Good                  Satisfactory                  Unsatisfactory

Would you have the same procedure performed upon yourself again? [ ] Yes [ ] No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.  
IT WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD  
AT NASHVILLE ORTHOPAEDIC SPECIALISTS.