ELBOW ASSESSMENT FORM AMERICAN SHOULDER AND ELBOW SURGEONS		
Name:		Date
Age:	Hand dominance: R L Ambi	Sex: M F
Diagnosis:		Initial Assess? Y N Follow-up: M Y
Procedure/Date:		Pharmacy: Pharmacy ph #:

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	[1] Yes	[2] No
b. Accomplished less than you would like	[1] Yes	[2] No
c. Were limited in the kind of work or other activities	[1] Yes	[2] No
d. Had difficulty performing the work or other activities (for example, it took extra effort)	[1] Yes	[2] 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	[1] Yes	[2] No
b. Accomplished less than you would like	[1] Yes	[2] No
c. Didn't do work or other activities as carefully as usual	[1] Yes	[2] 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?

[1] Not at all [2] Slightly [3] Moderately [4] Quite a bit [5] Extremely

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

[1] None [2] Very Mild [3] Mild [4] Moderate [5] Severe

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

[1] Not at all [2] A little bit [3] Moderately [4] Quite a bit [5] 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	A good bit 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	6
b. Have you been very nervous?	1	2	3	4	5	6
c. Have you felt so down in the dumps?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and blue?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been happy?	1	2	3	4	5	6
i. Do you feel tired?	1	2	3	4	5	6

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.

[1] All of the time [2] Most of the time [3] Some of the time [4] A little of the time [5] None of the time

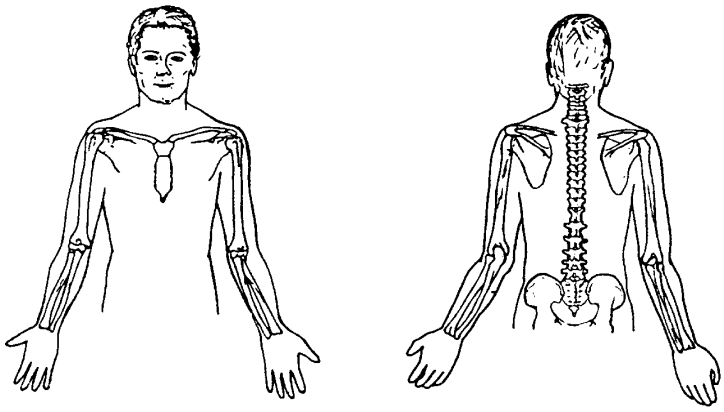
11. How true or false is each of the following statements for you?

	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

PATIENT SELF-EVALUATION

Are you having pain in your Elbow? (Circle correct answer)	Yes	No

Mark where your pain is on this diagram:



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	

Rate Your Elbow Pain: (Circle Number)

When it is at its worst

0 ____|____|____|____|____|____|____|____|____|____|____ 10

No Pain — Worst Pain Ever

At Rest

0 ____|____|____|____|____|____|____|____|____|____|____ 10

No Pain — Worst Pain Ever

Lifting a heavy object

0 ____|____|____|____|____|____|____|____|____|____|____ 10

No Pain — Worst Pain Ever

When doing a task with repeated elbow movements

0 ____|____|____|____|____|____|____|____|____|____|____ 10

No Pain — Worst Pain Ever

At night

0 ____|____|____|____|____|____|____|____|____|____|____ 10

No Pain — Worst Pain Ever

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

ACTIVITY		RIGHT ARM	LEFT ARM
1. Do up top button on shirt		0 1 2 3	0 1 2 3
2. Tie shoes		0 1 2 3	0 1 2 3
3. Eat with utensil		0 1 2 3	0 1 2 3
4. Manage toileting		0 1 2 3	0 1 2 3
5. Comb hair		0 1 2 3	0 1 2 3
6. Carry a heavy object		0 1 2 3	0 1 2 3
7. Raise from chair pushing with arm		0 1 2 3	0 1 2 3
8. Do heavy household chores		0 1 2 3	0 1 2 3
9. Turn a key		0 1 2 3	0 1 2 3
10. Throw a ball overhand		0 1 2 3	0 1 2 3
11. Do usual work – Describe:		0 1 2 3	0 1 2 3
12. Do usual sport – Describe:		0 1 2 3	0 1 2 3

PATIENT SELF-EVALUATION: SATISFACTION

Are You Satisfied With Your Elbow Surgery?

(Circle number if applicable)

0 |____|____|____|____|____|____|____|____|____|____| 10

Not At All Satisfied — Very Satisfied

Comments: _____

_____

_____

_____

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