POSM / OFALS
Elbow Subjective Follow-up

MEDICAL RECORD #

Name: _____

Physician: ○ KP ○ EB ○ Other
Any change in Hx: ○ Yes ○ No
Injured Elbow: ○ Right ○ Left ○ Both
Follow-up period: ○ 3 month ○ 6 month ○ 1 year ○ 2 yearly

EXAM DATE ☐☐ / ☐☐ / ☐☐☐☐

SURGERY DATE ☐☐ / ☐☐ / ☐☐☐☐

The following questions refer to your symptoms for a typical twenty-four-hour period during the past two weeks (choose one answer to each question)

How severe is the elbow pain that you have at night?
○ 1. I do not have hand or wrist pain at night ○ 2. Mild pain ○ 3. Moderate pain ○ 4. Severe pain ○ 5. Very severe pain

How often did the elbow pain wake you up during a typical night in the past two weeks?
○ 1. Never ○ 2. Once ○ 3. Two or three times ○ 4. Four or five times ○ 5. More than five times

Do you typically have pain in your elbow during the daytime?
○ 1. I never have pain during the day ○ 3. I have moderate pain during the day ○ 5. I have very severe pain during the day
○ 2. I have mild pain during the day ○ 4. I have severe pain during the day

How often do you have hand or wrist pain during the daytime?
○ 1. Never ○ 2. Once or twice a day ○ 3. Three to five times a day ○ 4. More than five times a day ○ 5. The pain is constant

How long, on average, does an episode of pain last during the daytime?
○ 1. I never get pain during the day ○ 3. 10 to 60 minutes ○ 5. The pain is constant throughout the day
○ 2. less than 10 minutes ○ 4. Greater than 60 minutes

Do you have numbness (loss of sensation) in your hand?
○ 1. No ○ 2. I have mild numbness ○ 3. I have moderate numbness ○ 4. I have severe numbness ○ 5. I have very severe numbness

Do you have weakness in your elbow and/ or hand or wrist?
○ 1. No weakness ○ 2. Mild weakness ○ 3. Moderate Weakness ○ 4. Severe Weakness ○ 5. Very severe Weakness

Do you have tingling sensations in your elbow/hand?
○ 1. No tingling ○ 2. Mild tingling ○ 3. Moderate tingling ○ 4. Severe tingling ○ 5. Very severe Weakness

How severe is numbness (loss of sensation) or tingling at night?
○ 1. I have no numbness or tingling at night ○ 2. Mild ○ 3. moderate ○ 4. Severe ○ 5. Very severe

How often did hand numbness or tingling wake you up during a typical night during the past two weeks?
○ 1. Never ○ 2. Once ○ 3. Two or three times ○ 4. Four or five times ○ 5. More than five times

Do you have difficulty with the grasping and use of small objects such as keys or pens?
○ 1. No difficulty ○ 2. Mild difficulty ○ 3. Moderate difficulty ○ 4. Severe difficulty ○ 5. Very severe difficulty

On a typical day during the past two weeks have hand and wrist symptoms caused you to have any difficulty doing the activities listed below? Please choose one number that best describes your ability to do the activity.

FUNCTION:	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Cannot do at all due to hand or wrist symptoms
Writing	○ 1	○ 2	○ 3	○ 4	○ 5
Buttoning of clothes	○ 1	○ 2	○ 3	○ 4	○ 5
Holding a book while reading	○ 1	○ 2	○ 3	○ 4	○ 5
Gripping of a telephone handle	○ 1	○ 2	○ 3	○ 4	○ 5
Opening of Jars	○ 1	○ 2	○ 3	○ 4	○ 5
Household chores	○ 1	○ 2	○ 3	○ 4	○ 5
Carrying of grocery bags	○ 1	○ 2	○ 3	○ 4	○ 5
Bathing and dressing	○ 1	○ 2	○ 3	○ 4	○ 5

Have you returned to work? ◯ Yes ◯ No ◯ Not Applicable (retired, student, etc.)

If YES, how long were you out of work due to this surgery/injury?

◯ No days missed
◯ Less than 1 week
◯ 1 - 2 weeks
◯ 3 - 5 weeks
◯ 6 - 8 weeks
◯ 2 - 4 months
◯ 5 - 8 months
◯ 9 - 12 months
◯ Greater than 1 year

If NO, choose one of the following reasons :

◯ Doctor instructions
◯ Other injury or surgery
◯ Other complications
◯ Symptoms from surgery/injury
◯ Can't perform work or sport
◯ Not because of hand

Since your injury\surgery, do you do ◯ less manual labor ◯ same manual labor ◯ more manual labor

How much keyboard/computer entry do you do in a day? ◯ a. <1 hour ◯ b. 3 hours ◯ c. 5 hours ◯ d. >7 hours

How much writing do you do in a day? ◯ a. <1 hour ◯ b. 3 hours ◯ c. 5 hours ◯ d. >7 hours

Is there a Worker's Compensation claim involved with your injury/surgery? ◯ YES ◯ NO IF **YES**, is this case: ◯ a. closed ◯ b. litigation still pending ◯ c. other

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If you had a re-injury requiring medical attention, when did the reinjury occur?

DATE: ☐☐ / ☐☐ / ☐☐☐☐ ◯ Not Applicable

How did the reinjury occur (check as many as apply)?

◯ No specific injury
◯ Overuse Injury
◯ Auto Accident
◯ Slip and/or Fall
◯ Work Accident
◯ Lifting Activity
◯ Participating in a RECREATIONAL Sport
◯ Participating in a SERIOUS RECREATIONAL/COMPETITIVE Sport
◯ Participating in a SCHOLASTIC COMPETITIVE Sport
◯ Participating in a PROFESSIONAL/WORLD CLASS Sport
◯ Other, PLEASE specify: ______________________

Rate the following on a scale from 10 to 1.	**Very Satisfied**				**Neutral**					**Very Unsatisfied**
How satisfied are you with your **MEDICAL** treatment at Plancher Orthopedics and Sports Medicine?	◯ 10	◯ 9	◯ 8	◯ 7	◯ 6	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
How satisfied are you with your **current OUTCOME**?	◯ 10	◯ 9	◯ 8	◯ 7	◯ 6	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1

Would you have an injection again? ◯ Yes ◯ No

Would you have surgery again? ◯ Yes ◯ No

Would you recommend your treatment to a relative or close friend with the same problem? ◯ Yes ◯ No

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Thank you for completing this questionnaire. If you have surgery, we will mail you a questionnaire each year following your surgery. Even if you feel great, we would like you to complete the form. If you would like to receive your questionnaires via e-mail please enter your e-mail address here:

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By completing this form, you agree to allow the Orthopaedic Foundation for Active Lifestyles & Plancher Orthopaedic and Sports Medicine to use this data and future questionnaire data for research and contact purposes only. All data is kept anonymous. It is our goal to monitor patient outcomes in an effort to improve quality of care. Your input is crucial to our mission. If you have any questions or would like more information about the foundation or clinic, please contact us .