Upper Limb-DASH

Follow-Up Questionnaire

This questionnaire includes the SF-36™ Standard Version 2.0 Health Survey, item numbers 19 to 29 in this questionnaire.

Developed by:

American Academy of Orthopaedic Surgeons®

Institute for Work and Health, Toronto

American Association for Hand Surgery

American Society for Surgery of the Hand

American Orthopaedic Society for Sports Medicine

American Shoulder and Elbow Surgeons

Arthroscopy Association of North America

American Society of Plastic and Reconstructive Surgeons

Outcomes Data Collection Questionnaires January 2000 Version 2000 (reformatted for easier use)

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Clinic ID _____ First six letter of patient's last name _____

Physician ID_____ Office Chart # _____

	Diagnosis & ICD-9 Code*	Procedure & CPT Code**	CPT Date	Side of body procedure was performed on:
Primary DX	DX ICD-9	Tx CPT		☐ Right ☐ Left ☐ Both ☐ N/A
Secondary DX	DX ICD-9	Tx CPT		☐ Right ☐ Left ☐ Both ☐ N/A
Secondary DX	DX ICD-9	Tx CPT		☐ Right ☐ Left ☐ Both ☐ N/A
Secondary DX	DX ICD-9	Tx CPT		☐ Right ☐ Left ☐ Both ☐ N/A
Secondary DX	DX ICD-9	Tx CPT		☐ Right ☐ Left ☐ Both ☐ N/A

* Please fill in the complete diagnosis in the space provided above the dotted line and the corresponding ICD-9 code in the space below the dotted line. (See example below)

** Please fill in the complete procedure in the space provided above the dotted line and the corresponding CPT code in the space below the dotted line. (See example below)

	Diagnosis & ICD-9 Code*	Procedure & CPT Code**	CPT Date	Side of body procedure was performed on:
Primary DX	DX *degenerative shoulder* ICD-9 *718.01*	Tx *Arthroplasty, total shoulder* CPT *23472*	*4/1/97*	☒ Right ☐ Left ☐ Both ☐ N/A

Today's Date / /

Thank you for completing this questionnaire!

This questionnaire will help us to better understand your general health and any problems related to bone and muscle conditions.

Your completion of this questionnaire is completely voluntary and your responses will be held in the strictest confidence.

Please answer every question. Some questions may look like others, but each one is different.

There are no right or wrong answers. If you are not sure how to answer a question, just give the best answer you can. You can make comments in the margin. We do read all your comments, so feel free to make as many as you wish.

Your Birth Date / /

Your Social Security Number _____

Current Health Assessment

Instructions

The following is a list of common health problems. Please circle yes or no in the first column, then go on to the next item. If you do have the problem indicate in the second column if you receive medications or some other type of treatment for the problem. In the last column, indicate if the problem limits any of your activities.

		Do you have the problem?		**Do you receive treatment for it?**		**Does it limit your activities?**	
4.	Heart Disease	Yes	No	Yes	No	Yes	No
5.	High Blood Pressure	Yes	No	Yes	No	Yes	No
6.	Lung Disease	Yes	No	Yes	No	Yes	No
7.	Diabetes	Yes	No	Yes	No	Yes	No
8.	Ulcer or Stomach Disease	Yes	No	Yes	No	Yes	No
9.	Kidney Disease	Yes	No	Yes	No	Yes	No
10.	Liver Disease	Yes	No	Yes	No	Yes	No
11.	Anemia or Other Blood Disease	Yes	No	Yes	No	Yes	No
12.	Cancer	Yes	No	Yes	No	Yes	No
13.	Depression	Yes	No	Yes	No	Yes	No
14.	Osteoarthritis/Degenerative Arthritis	Yes	No	Yes	No	Yes	No
15.	Back Pain	Yes	No	Yes	No	Yes	No
16.	Rheumatoid Arthritis	Yes	No	Yes	No	Yes	No
17.	Other Medical Problem (please specify)	Yes	No	Yes	No	Yes	No

_____; _____

18. Do you now have any of the following conditions? (Circle all that apply.)

1 Seasonal allergies such as hay fever
2 Dermatitis or other chronic skin conditions
3 Limitation in the use of an arm or leg (missing, paralyzed or weakness)
4 Chronic allergies or sinus troubles
5 Trouble seeing with one or both eyes, even when wearing glasses or blindness
6 Deafness or trouble hearing with one or both ears
7 Hemorrhoids

19a. Compared to when you last completed this questionnaire, is your musculoskeletal condition:

1 Much better now 2 Somewhat better now 3 About the same 4 Somewhat worse now 5 Much worse now

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

1 Excellent 2 Very Good 3 Good 4 Fair 5 Poor

20. **Compared to <u>one year ago,</u>** how would you rate your health in general **now**?

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

Current Health Assessment

21. 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? (Circle one response for each statement.)

		Yes, limited a lot	Yes, limited a little	No, not limited at all
a.	Vigorous activities, such as running, lifting heavy objects, or 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 hundred yards	1	2	3
i.	Walking one hundred yards	1	2	3
j.	Bathing or dressing yourself	1	2	3

22. During the **past four weeks, how much of the time** have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (Circle one response for each statement.)

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a.	Cut down the amount of time you spent on work or other activities	1	2	3	4	5
b.	Accomplished less than you would like	1	2	3	4	5
c.	Were limited in the kind of work or other activities	1	2	3	4	5
d.	Had difficulty performing the work or other activities (for example, it took extra effort)	1	2	3	4	5

23. During the **past four weeks, how much of the time** 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)? (Circle one response for each statement.)

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a.	Cut down the amount of time you spent on work or other activities	1	2	3	4	5
b.	Accomplished less than you would like	1	2	3	4	5
c.	Did work or other activities less carefully than usual	1	2	3	4	5

Current Health Assessment

24. During the **past four weeks,** to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups? (Circle one response.)

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

25. How much bodily pain have you had during the **past four weeks**? (Circle one response.)

1 None 2 Very mild 3 Mild 4 Moderate 5 Severe 6 Very severe

26. During the **past four weeks,** how much did pain interfere with your normal work (including both work outside the home and housework)? (Circle one response.)

1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

27. These questions are about how you feel and how things have been with you during the **past four weeks.** For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past four weeks**… (Circle one response for each statement.)

		All 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 life?	1	2	3	4	5
b.	Have you been very nervous?	1	2	3	4	5
c.	Have you felt so down in the dumps that nothing could cheer you up?	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 depressed?	1	2	3	4	5
g.	Did you feel worn out?	1	2	3	4	5
h.	Have you bee happy?	1	2	3	4	5
i.	Did you feel tired?	1	2	3	4	5

28. During the **past four weeks,** how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc)? (Circle one response.)

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

Current Health Assessment

29. Please choose the answer that best describes how true or false each of the following statements is for you. (Circle one response on each line.)

		Definitely True	Mostly True	Not sure	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

30. What medications, if any, are you currently taking for your back? (Circle all that apply.)

1 None
2 Muscle relaxants (Valium)
3 Non-steroids (ie, Motrin)
4 Narcotics (Morphine)
5 Steroids (Cortisone)

31a. What treatment(s) (surgery, medication, therapies) have you had since you previously completed this questionnaire?

1 None 2 Surgery 3 Physical/Occupational Therapy 4 Splint or Brace
5 Cast(s) 6 Medication 7 Shoe Inserts 8 Other _____

31. During the **past week,** how often have you taken pain medication, including narcotics or over-the-counter medications? (Circle one response.)

1 Three or more times a day 2 Once or twice a day 3 Once every couple of days 4 Once a week 5 Not at all

32. Do you currently smoke cigarettes? (Circle one response.)

1 Yes 2 No, I quit in the last 12 months 3 No, I quit more than 12 months ago 4 I have never smoked

33. Have you ever smoked at least 100 cigarettes in your entire life? (Circle one response.)

1 Yes 2 No 3 Don't know

34. Do you now smoke every day, some days, or not at all? (Circle one response.)

1 Every day 2 Some days 3 Not at all 4 Don't know

35. How long has it been since you quit smoking cigarettes? (Circle one response.)

1 Less than 12 months 2 12 months or more 3 Don't know

Current Health Assessment

Are the results of your treatment what you expected? (Circle one response on each line.)

The results of my treatment met my expectations for:		Definitely yes	Probably yes	Not sure	Probably not	Definitely not	Not applicable
36.	Relief from symptoms (pain, stiffness, swelling, numbness, weakness, instability)	1	2	3	4	5	6
37.	To do more everyday household or yard activities	1	2	3	4	5	6
38.	To sleep more comfortably	1	2	3	4	5	6
39.	To go back to my usual job	1	2	3	4	5	6
40.	To exercise and do recreational activities	1	2	3	4	5	6

41. If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it? (Circle one response.)

1 Very dissatisfied 2 Somewhat dissatisfied 3 Neutral 4 Somewhat satisfied 5 Very satisfied

41a. If you could **go back in time** and make the decisions again, would **you choose the same treatment** for your musculoskeletal condition/problem? (Circle one response.)

1 Definitely yes 2 Probably yes 3 Completely uncertain 4 Probably not 5 Definitely not

42. For your **front right side** please indicate those areas that bother you or limit your function.

1	Neck	2	Shoulder area	3	Elbow/Forearm
4	Wrist/Hand	5	Hip	6	Thigh
7	Knee area	8	Calf area	9	Ankle/Foot area

43. For your **front left side** please indicate those areas that bother you or limit your function.

1	Neck	2	Shoulder area	3	Elbow/Forearm
4	Wrist/Hand	5	Hip	6	Thigh
7	Knee area	8	Calf area	9	Ankle/Foot area

44. For your **back** please indicate those areas that bother you or limit your function.

1	Neck	2	Upper Back	3	Lower Back

Upper Limb-DASH Questionnaire

Instructions

This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer **every** question based on your condition during the **past week**. If you did not have the opportunity to perform an activity in the past week, please make your **best guess** as to which response would be the most accurate. It does not matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Please rate your ability to do the following activities in the **past week**.
(Circle one response on each line.)

		No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
45.	Open a tight or new jar	1	2	3	4	5
46.	Write	1	2	3	4	5
47.	Turn a key	1	2	3	4	5
48.	Prepare a meal	1	2	3	4	5
49.	Push open a heavy door	1	2	3	4	5
50.	Place an object on a shelf above your head	1	2	3	4	5
51.	Do heavy household chores (eg, wash walls, wash floors)	1	2	3	4	5
52.	Garden or do yard work	1	2	3	4	5
53.	Make a bed	1	2	3	4	5
54.	Carry a shopping bag or briefcase	1	2	3	4	5
55.	Carry a heavy object (over 10 lbs.)	1	2	3	4	5
56.	Change a lightbulb overhead	1	2	3	4	5
57.	Wash or blow dry your hair	1	2	3	4	5
58.	Wash your back	1	2	3	4	5
59.	Put on a pullover sweater	1	2	3	4	5
60.	Use a knife to cut food	1	2	3	4	5
61.	Recreational activities which require little effort (eg, card playing, knitting, etc.)	1	2	3	4	5
62.	Recreational activities in which you take some force or impact through your arm, shoulder or hand (eg, golf, hammering, tennis, etc.)	1	2	3	4	5
63.	Recreational activities in which you move your arm freely (eg, playing frisbee, badminton, etc.)	1	2	3	4	5
64.	Manage transportation needs (getting from one place to another)	1	2	3	4	5
65.	Sexual activities	1	2	3	4	5

Upper Limb-DASH Questionnaire

66. During the **past week, to what extent** has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups? (Circle one response.)

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

67. During the **past week,** were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problems? (Circle one response.)

1 Not limited at all 2 Slightly Limited 3 Moderately Limited 4 Very Limited 5 Unable

Please rate the severity of the following symptoms in the **past week**.
(Circle one response on each line.)

		None	Mild	Moderate	Severe	Extreme
68.	Arm, shoulder or hand pain	1	2	3	4	5
69.	Arm, shoulder or hand pain when you performed any specific activity	1	2	3	4	5
70.	Tingling (pins and needles) in your arm, shoulder or hand	1	2	3	4	5
71.	Weakness in your arm, shoulder or hand	1	2	3	4	5
72.	Stiffness in your arm, shoulder or hand	1	2	3	4	5

73. During the **past week,** how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (Circle one response.)

1 No difficulty 2 Mild difficulty 3 Moderate difficulty 4 Severe difficulty 5 So much difficulty that I can't sleep

74. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. (Circle one response.)

1 Strongly disagree 2 Disagree 3 Neither agree or disagree 4 Agree 5 Strongly agree

Upper Limb-DASH Questionnaire

The following questions relate to the impact of your arm, shoulder or hand problem on **playing your musical instrument or sport, or both.** If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you: _____

Please circle one response on each line that best describes your physical ability in the past week.

Did you have any difficulty:

		No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
75.	Using your usual technique for playing your sport or instrument?	1	2	3	4	5
76.	Playing your sport or musical instrument because of arm, shoulder or hand pain?	1	2	3	4	5
77.	Playing your sport or musical instrument as well as you would like?	1	2	3	4	5
78.	Spending your usual amount of time practicing or playing your sport or musical instrument?	1	2	3	4	5

The following questions relate to the impact of your arm, shoulder or hand problem on **your work.**

Please circle one response on each line that best describes your physical ability in the past week.

Did you have any difficulty:

		No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
79.	Using your usual technique for your work?	1	2	3	4	5
80.	Doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
81.	Doing your work as well as you would like?	1	2	3	4	5
82.	Spending your usual amount of time doing your work?	1	2	3	4	5

Tell us about you!

83. Your gender

1 ☐ Male 2 ☐ Female

84. Your Height _____ Your Weight _____

85. Your race (Check all that apply.)

1 ☐ White

2 ☐ Black or African-American

3 ☐ Hispanic

4 ☐ Asian or Pacific Islander

5 ☐ Native American Indian

6 ☐ Other (please specify) _____

86. How much schooling have you completed?

1 ☐ Less than high school

2 ☐ Graduated from high school

3 ☐ Some college

4 ☐ Graduated from college

5 ☐ Postgraduate school or degree

87. What is your current marital situation?

1 ☐ Married 2 ☐ Living with significant other 3 ☐ Divorced/Separated 4 ☐ Widowed 5 ☐ Single (never married)

88. Do you live with someone who can take care of you?

1 ☐ Yes 2 ☐ No

89. Which statements describe your current employment situation? (Check all that apply.)

1 ☐ Currently working

2 ☐ On leave of absence

3 ☐ Unemployed

4 ☐ Homemaker

5 ☐ Student

6 ☐ Retired (not due to ill health)

7 ☐ Disabled and/or Retired due to ill health

8 ☐ Other, please specify _____

90. Are you currently on or planning to apply to any of the following programs? (Please circle 1 Yes or 2 No)

		Already on it		**Applied for it**		**Planning to apply for it**	
a.	Social Security	1 Yes	2 No	1 Yes	2 No	1 Yes	2 No
b.	Disability	1 Yes	2 No	1 Yes	2 No	1 Yes	2 No
c.	Workers Compensation	1 Yes	2 No	1 Yes	2 No	1 Yes	2 No