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# QUESTIONNAIRE FOR THORACIC OUTLET SYNDROME

******** PLEASE PRINT ALL ANSWERS ********

**If additional space is needed, please use back of page.**

**NOTE TO PATIENT:** I apologize for the length of this questionnaire. However, this is one of the most difficult diagnoses of medicine to work through and formulate a treatment plan. It may take more than one visit and may take many visits to work through this for myself and all of your physicians involved. Your time and attention to providing the information is not only critical to your care but appreciated.

**Patient Name** _____ **Date:** _____

1. Where do you hurt? ☐ Neck

| **Right** | **Left** |
|---|---|
| ☐ Shoulder | ☐ Shoulder |
| ☐ Upper Arm | ☐ Upper Arm |
| ☐ Forearm | ☐ Forearm |
| ☐ Fingers | ☐ Fingers (Fingers are defined below) |

2. Is there numbness? ☐ Neck

| **Right** | **Left** |
|---|---|
| ☐ Shoulder | ☐ Shoulder |
| ☐ Upper Arm | ☐ Upper Arm |
| ☐ Forearm | ☐ Forearm |
| ☐ Fingers | ☐ Fingers (Fingers are defined below) |

3. If fingers, which fingers:

| **Hurt** | | | **Numb** | | |
|---|---|---|---|---|---|
| ☐ Thumb | ☐ R | ☐ L | ☐ Thumb | ☐ R | ☐ L |
| ☐ Index finger | ☐ R | ☐ L | ☐ Index finger | ☐ R | ☐ L |
| ☐ Middle finger | ☐ R | ☐ L | ☐ Middle finger | ☐ R | ☐ L |
| ☐ Ring finger | ☐ R | ☐ L | ☐ Ring finger | ☐ R | ☐ L |
| ☐ Little finger | ☐ R | ☐ L | ☐ Little finger | ☐ R | ☐ L |

4. What are you doing when you have the worst symptoms? _____

_____

5. Do any of these symptoms ever go away? ☐ Yes ☐ No If Yes, which ones? _____

_____

6. Does your discomfort change with position? ☐ Yes ☐ No If Yes, what position is the worst? _____

_____

7. What position relieves discomfort the most? _____

8. Does your arm swell? **Right** ☐ Yes ☐ No **Left** ☐ Yes ☐ No If Yes, was this

☐ Gradual onset? ☐ Sudden onset?

**CONTINUED**

9. Do you have a history of having had blood clots? ☐ Yes ☐ No If Yes,

When? _____

Where? _____

10. Are the veins in your arm distended in any position? **Right**: ☐ Yes ☐ No **Left**: ☐ Yes ☐ No

If Yes, what position?_____

11. Do you have problems reaching overhead to:

☐ Change a light bulb? ☐ Paint a wall? ☐ Comb your hair?

If Yes, what happens with these maneuvers? _____

If other overhead activities cause problems, please describe: _____

_____

12. Do you awaken after a night's sleep with problems in your: ☐ Neck

| **Right** | **Left** |
|---|---|
| ☐ Shoulder | ☐ Shoulder |
| ☐ Upper Arm | ☐ Upper Arm |
| ☐ Forearm | ☐ Forearm |
| ☐ Fingers: Thumb Index Middle Ring Little | ☐ Fingers: Thumb Index Middle Ring Little |

13. Have you ever had an injury to your neck? ☐ Yes ☐ No If Yes, please list each incident.

| **Year** | **Incident** | **Treatment** (Therapy, Surgery, etc.) | **X-rays?** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

14. Have you ever been in a car wreck? ☐ Yes ☐ No If Yes please describe the wreck. _____

_____

Were you restrained? ☐ Yes ☐ No Were you the: ☐ Driver ☐ Passenger

Were you in the ☐ Front Seat ☐ Back Seat

What was the point of impact on the car? _____

Did the airbags deploy? ☐ Yes ☐ No Did the car have to be towed away? ☐ Yes ☐ No

Did you hit the windshield? ☐ Yes ☐ No If Yes did your head score the windshield? ☐ Yes ☐ No

If you were rear ended, did your seat break? ☐ Yes ☐ No

Where did you come to rest? _____

Did your seatbelt hold? ☐ Yes ☐ No Were you ejected? ☐ Yes ☐ No

Did you have x-rays after the wreck? ☐ Yes ☐ No

If Yes were they ☐ Regular x-rays ☐ CT scan ☐ MRI

How long after the wreck was it before you realized you had problems and sought medical care? _____

_____

15. Have you injured your arm? ☐ Yes ☐ No How did it happen? _____

_____

Was this event related to trauma? ☐ Yes ☐ No Were you at work? ☐ Yes ☐ No

How long after the injury was it before you realized that something had happened? _____

16. What type of work do you do? _____

At what level are your arms when you work? _____

Are there repetitive motions at this level? ☐ Yes ☐ No

How long do you work at this level? _____

If a desk job, does your chair have adjustable arms? ☐ Yes ☐ No

What is the height of your computer keyboard? _____

Do you have wrist support in front of your keyboard? ☐ Yes ☐ No

17. Have you ever had to stop work: ☐ Temporarily? For how long? _____

☐ Sick leave? For how long? _____

☐ Disability? For how long? _____

18. Have you ever had a stroke? ☐ Yes ☐ No

19. Have you ever had a head injury? ☐ Yes ☐ No

20. Do you have headaches? ☐ Yes ☐ No

If Yes have they changed in the last ☐ Week ☐ Months ☐ Years If Yes, how? _____

_____

21. Do you have ☐ Numbness or ☐ Weakness or ☐ Decreased muscle function in your legs?

If yes, please describe: **Right:** _____

**Left:** _____

22. Do you have ☐ Numbness or ☐ Weakness or ☐ Decreased muscle function in your arms?

If yes, please describe: **Right:** _____

**Left:** _____

23. Do your fingers turn white or blue and then hurt and turn bright red when exposed to cold? ☐ Yes ☐ No

24. Have you had physical therapy? ☐ Yes ☐ No If Yes please describe:

| Year | Treatment |
|---|---|
| | |
| | |
| | |

**CONTINUED**

25. Please describe exercises you have done:

| Exercise | Helped | Worse |
|---|---|---|
| | | |
| | | |
| | | |

If any exercise made your symptoms worse, please describe which maneuvers made them worse. _____

_____

Have you had recent EMG and nerve conduction studies? ☐ Yes ☐ No If Yes, date: _____

Have you had previous EMG and nerve conduction studies? If yes, date: _____

26. Have you had an MRI of your neck? ☐ Yes ☐ No If Yes, date: _____

Where was it performed? _____

27. Have you had a CT? ☐ Yes ☐ No If Yes, date: _____

28. Do you have a lawyer? ☐ Yes ☐ No

29. Are you involved in a lawsuit? ☐ Yes ☐ No

30. Are you involved in a Workers Comp dispute? ☐ Yes ☐ No

31. What physical therapist have you seen? _____

32. What physicians have you seen and dates:

| Date | Physician |
|---|---|
| | |
| | |
| | |

33. What did the other physicians recommend? _____

_____

34. Have you been to Pain Management? ☐ Yes ☐ No

35. Do you have any questions for me? _____

_____

_____

Many of the questions I have asked you may not have thought about and you may have to notice over the next few weeks what is happening to you. This is not at all unusual because of the complexity. The odds are very likely that I will see you more than once and each time we may go through many of the same questions. We will also possibly recommend limited physical therapy of only some maneuvers and not likely near the number of exercises you have been through. Some maneuvers actually aggravate the problem while some help the problem.