Mass General Thoracic Outlet Syndrome Program Questionnaire

Thank you for completing this form. This must be completed and returned by fax to 617-726-7667, by email or by mail to Dr. Donahue’s office (address below) as soon as possible. For more information, please visit our website at: www.massgeneral.org/tos-program

Dean M. Donahue, MD
Massachusetts General Hospital
Founders 7
55 Fruit Street
Boston, MA 02114
Email: thoracicoutletsyndrome@partners.org
Phone: 617-724-0969
Fax: 617-726-7667

We sincerely appreciate your interest in Massachusetts General Hospital.

Today’s Date: ________________________

General Information

Patient’s name: ____________________________________________________________

Best contact phone number: ___________________________ Date of birth: _____ / _____ / _____

Email address: ____________________________________________________________

Mass General Medical Record Number (MRN): ______________________________________
(If you do not have a MRN, please call Mass General Registration at 866-211-6588.)

Primary Care Physician: ______________________________________________________

Address: __________________________________________________________________

Who referred you to Dr. Donahue? Name: _______________________________________

Address: __________________________________________________________________

Do you have a Pain Management Physician? Name: _______________________________

Address: __________________________________________________________________

Do you have a Neurologist? Name: _____________________________________________

Address: __________________________________________________________________
Timeline of Events Leading Up to This Appointment

List your initial symptoms and the date they developed. Then, add any additional symptoms that developed and the approximate date they started.

Are you experiencing symptoms on the RIGHT______LEFT_____ BOTH_____

Are you RIGHT or LEFT handed?  RIGHT_____ LEFT_____ Ambidextrous______

What caused your symptoms? Did the symptoms come on gradually or suddenly? Did an event occur?

Overall pain level or level of discomfort from 0-10, 10 being the worst pain you have experienced.

Please list the medications that you are currently taking, including doses and the prescriber.
Select any previous testing you have had done related to your symptoms. Discs and reports must be sent prior to booking your initial appointment. (We recommend you obtain a copy of your imaging and reports, then mail directly to us with a tracking number.)

- □ Ultrasound
- □ X-Ray
- □ Venogram
- □ EMG
- □ MRI
- □ CT

□ Any additional testing:

Have you been in physical therapy for your symptoms?

Any other pertinent information?

**Symptoms**

**Pain:** If you have pain, please indicate the location below.

Please rate your pain: 1 (mild) - 10 (worst pain you have ever experienced), and indicate how often this occurs A (always) O (often) S (sometimes) R (rarely)

<table>
<thead>
<tr>
<th>Location</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head (headache)</td>
<td>A</td>
</tr>
<tr>
<td>Face</td>
<td>O</td>
</tr>
<tr>
<td>Neck</td>
<td>S</td>
</tr>
<tr>
<td>Axilla (armpit)</td>
<td>O</td>
</tr>
<tr>
<td>Shoulder</td>
<td>O</td>
</tr>
<tr>
<td>Arm</td>
<td>S</td>
</tr>
<tr>
<td>Shoulder blade</td>
<td>O</td>
</tr>
<tr>
<td>Hand</td>
<td>O</td>
</tr>
<tr>
<td>Upper Back</td>
<td>O</td>
</tr>
<tr>
<td>Fingers</td>
<td>R</td>
</tr>
</tbody>
</table>

**Numbness, Tingling, “pins and needles”:** Please indicate location and how often this occurs. A (always) O (often) S (sometimes) R (rarely)

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<td>Head/Face</td>
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<td>O</td>
</tr>
<tr>
<td>Arm</td>
<td>S</td>
</tr>
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</table>

Last Updated 08/2018
Shoulder blade _____  Hand ___

Upper back _____  Fingers _____ Which fingers?  Thumb __ 2nd __ 3rd __ 4th __ 5th ___

**Do you have muscle weakness?** Arm ________ Hand ________

Please list the activities you have difficulty with: (such as writing, computer use, lifting above shoulder height, dropping things, throwing)

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**Color and Temperature change:**

Please indicate if your hands, fingers get cold, hot, red, bluish, pale.

Arm ________

Hand ______________

Fingers_____________

**Swelling:** Please indicate if you experience swelling in the fingers, hand, arm.

Arm___________

Hand__________

Fingers_______

**Dizzy, vertigo, tinnitus:** Please indicate if you ever feel dizzy or ringing in ears and what brings this on.

Dizzy (room spinning) ______

Unsteady (listing as if on a boat)_______

Tinnitus (ringing in your ears)_______

Other: Please list any other symptoms not otherwise mentioned.

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**Past Medical/Surgical History**

Height: ____________  Weight: ______________
Please list ALL other past or current medical problems, even if they are unrelated to TOS.

Please list ALL operations that you have had and the year you had them.

Do you have any allergies to medications? Please list.

Are you allergic to IV Contrast? Yes_____ No_____

**Review of Systems:**
Please place an “X” if any of the following symptoms apply to you.

- fatigue _____
- fever _____
- chills_____
- sweats_____
- loss of appetite _____ weight loss _____
- dysphagia _____
- history of ulcer disease _____
- symptoms of angina _____ palpitations _____
- cough _____
- shortness of breath with exertion _____
- asthma _____
- lightheadedness _____
- dizziness _____
- history of stroke _____ or seizure _____
- change in vision _____ hearing _____ voice _____
- history of diabetes _____ or thyroid disease _____
- frequent urination _____ Painful urination _____ History of kidney stones _____
• arthritis _____ weakness _____
• history of anxiety _____ or depression _____
• bruising _____ bleeding problems ___ on blood thinning medication including aspirin _____

Substance Use History:
Do you currently smoke? Yes_____ No_____ Smokeless tobacco/vaping_____  
If so, how much do you smoke and for how many years? ______________________________
If you are a former smoker, how much did you smoke and for how many years? ____________
How often and how much alcohol do you currently drink? ______________________________
Do you have a history of alcoholism/alcohol or drug abuse? _____________________________

Family History:
Please list any medical problems in your family or causes of death:

Mother: _________________________________________________________________________
Father: ________________________________________________________________________
Brothers/Sisters: __________________________________________________________________
Sons/Daughters: __________________________________________________________________

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