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: ____________________________________________________________________
Description of your Symptom History

Please describe your initial symptoms and when they occurred. Then, add any additional symptoms in the order that they developed and the approximate date that those symptoms started. It may be helpful to start with a rough draft, then check to see if any symptoms or events were excluded before completing this form.

What is the symptom? Which date did it first occur?

__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________

Are you experiencing symptoms on the RIGHT_____ LEFT_____ BOTH_____

Are you RIGHT or LEFT handed? RIGHT_____ LEFT_____ Ambidextrous_______

Overall pain or level of discomfort you have been experiencing. Circle one:
0  1  2  3  4  5  6  7  8  9
No pain/discomfort Pain/discomfort at its worst

Please list the medications that you are currently taking, including doses and the prescriber.

Name of Med  Dose  Prescriber
________________________
________________________
________________________
________________________

**Do not skip questions above. This is critical for our evaluation.**
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             ☐ Any additional testing:

☐ CT

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)

Head (headache)/Face ______  Chest ______

Neck ______  Axilla (armpit) ______

Shoulder ______  Arm ______

Shoulder blade ______  Hand ______

Upper Back ______  Fingers ______ Which fingers? Thumb ______ 2 nd ______ 3 rd ______ 4 th ______ 5 th ______

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

Head/Face ______  Chest ______  Shoulder blade ______  Fingers ______ Which fingers?

Neck ______  Axilla (armpit) ______  Upper back ______  Thumb ______ 2 nd ______ 3 rd ______ 4 th ______ 5 th ______

Shoulder ______  Arm ______  Hand ______
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)

_____________       _____________       _____________       _____________
_____________       _____________       _____________       _____________
_____________       _____________       _____________       _____________

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:

_____________       _____________       _____________       _____________
_____________       _____________       _____________       _____________
_____________       _____________       _____________       _____________
Past Medical/Surgical History

Height: _____________   Weight: ________________

Please list ALL additional 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? Y/N
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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