

ELBOW HISTORY

NAME: _____ DATE: _____
Last Name First Name Middle Initial

Please answer each of the following questions by checking as many responses as necessary. If the answer you need is not available, please feel free to write it in.

How old are you? _____ What is your occupation? _____
Which is your **dominant** arm? _____ Right _____ Left
Where do you live(City, State)? _____
Who referred you to our office? _____ Previous patient? _____ Yes _____ No
With which elbow are you experiencing difficulty? _____ Right _____ Left _____ Both
_____ Right worse then left
_____ Left worse then right

How long have you been experiencing difficulty with your elbow? _____
What do you think may have caused your elbow symptoms (for example, spontaneous, over use exercise, specific injury an accident)? _____

Which of the following elbow symptoms are you experiencing? **Please mark all that apply by ranking them in order of decreasing severity with one (1) as most significant symptom.**

- | | |
|--|---|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Popping |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Tearing |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness/ Tingling |
| <input type="checkbox"/> Instability/ slipping sensation | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Dislocation | |

Where do you experience the majority of your elbow?
 At the front of the elbow On the outer side of the elbow
 At the back of the elbow Generalized pain throughout the elbow
 On the inner side of the elbow

Does your elbow pain radiate (move)?
 NO Down your forearm Up into your upper arm

Please check all that apply to your elbow discomfort:
 Aching Constant
 Sharp Intermittent
 Burning Present only with certain activities

Please mark the severity of your elbow discomfort on a scale of 1 to 10 on the line below
(1= minimal, 10= extremely severe) |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
1 5 10
Minimal Moderate Severe

Do you have difficulty reaching or moving your elbow in any of the following directions?
 Bending Straightening Rotation

Does your elbow problem interfere with any of the following:

Daily activities

School activities

Work activities

Recreation or sports activities

Please explain: _____

Do you experience elbow pain at night which interferes with your sleep? Yes No

Have you previously had your elbow evaluated by:

Primary care physician

Another orthopedic surgeon

Emergency room visit

Have you had any of the following imaging studies for your elbow?

X-ray

CT scan

MRI

Bone scan

Arthogram

Other _____

Please check any treatments that you have tried for your elbow condition?

Has treatment helped?

Rest

Yes

No

Ice application

Yes

No

Anti-inflammatory medications(which ones) _____

Yes

No

Pain Medication (which ones) _____

Yes

No

Cortisone injection(last one) _____

Yes

No

Immobilization/ sling

Yes

No

Physical therapy

Yes

No

Other _____

Yes

No

How is your elbow progressing?

Getting better

Staying the same

Getting worse

Have you ever had any other significant elbow injuries in the past? Yes No

If yes, please explain: _____

If yes, did you fully recover? Yes No

Have you ever had elbow surgery? Yes No

If yes, please explain(date, doctor, procedure if known): _____

Please list any other information you feel would assist your doctor with your treatment.

