

ELBOW HISTORY

NAME: _____
Last Name First Name Middle Initial

DATE: _____

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? _____ Is the referring person a previous patient? _____ Yes _____ No

With which elbow are you experiencing difficulty? _____ Right _____ Left _____ Both
_____ Right worse than left
_____ Left worse than right

How long have you been experiencing difficulty with your elbow? _____

On what date did your symptoms begin (if known)? _____

What do you think may have caused your elbow symptoms (for example, spontaneous, overuse, 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"/> Locking/ Catching |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Popping/ Grinding |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness/ Tingling |
| <input type="checkbox"/> Instability/ slipping sensation | <input type="checkbox"/> Swelling |
| | <input type="checkbox"/> Other _____ |

Where do you experience the majority of your elbow pain?

- | | |
|---|--|
| <input type="checkbox"/> At the front of the elbow | <input type="checkbox"/> On the outer side of the elbow |
| <input type="checkbox"/> At the back of the elbow | <input type="checkbox"/> Generalized pain throughout the elbow |
| <input type="checkbox"/> On the inner side of the elbow | |

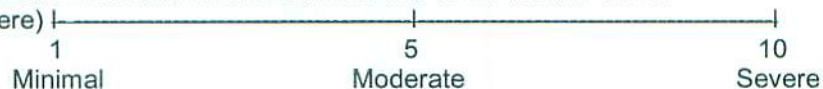
Does your elbow pain radiate (move)?

- | | | |
|-----------------------------|---|---|
| <input type="checkbox"/> NO | <input type="checkbox"/> Up into your upper arm | <input type="checkbox"/> Down into your forearm |
|-----------------------------|---|---|

Please check all that apply to your elbow discomfort:

- | | |
|----------------------------------|---|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Intermittent |
| <input type="checkbox"/> Burning | <input type="checkbox"/> 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)



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Does your elbow problem interfere with any of the following?

____ Daily activities
____ Work activities

____ School 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? Please include dates, if known.

____ X-ray
____ MRI
____ CT Scan

____ Bone Scan
____ Other _____

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

____ Rest
____ Ice application
____ Anti-inflammatory medications (Which medications) _____
____ Pain Medication (Which medications) _____
____ Cortisone injection (Date) _____
____ Immobilization/ brace
____ Physical therapy
____ Other _____

Has treatment helped?

____ Yes ____ No
____ Yes ____ No
____ Yes ____ No
____ Yes ____ No
____ Yes ____ No
____ Yes ____ No
____ 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.

