ELBOW HISTORY

NAME:_____DOB: _____ DATE:_____
Please print: First name, middle initial, last name

How old are you? _____ What is your occupation? _____ Height _____ Weight _____

Where do you live (City, State)? _____ Were you referred by another physician?

Who may we thank for your referral to our office? _____ Physician or Patient (circle one)

Elbow experiencing difficulty? ____Right ____Left ____Both, which is worse_____ Dominance? ___Right ___Left

On what date did your symptoms begin? _____ If unknown how long have you been experiencing difficulty with your arm? _____

What do you think may have caused your elbow symptoms (spontaneous, overuse, exercise, accident, work injury)

_____

Describe how you were injured: _____

_____

Please mark all that apply by ranking them in order of decreasing severity with one (1) as most significant symptom.

Which of the following elbow symptoms are you experiencing?

____Pain ____Locking/catching ____Weakness ____Instability/slipping sensation
____Stiffness ____Grinding/popping ____Swelling ____Numbness/Tingling

Where do you experience the majority if your elbow pain?

____Front of your elbow ____Top of your elbow ____Inner side of your elbow
____Back of your elbow ____Generalized Pain ____Outer side of your elbow

Does your elbow pain radiate (move) ____No ____Down your arm ____Up your arm

Please check all that apply to your elbow discomfort:

____Aching ____Constant ____Burning
____Sharp ____Intermittent ____Present only with certain activities

Please mark the severity of your elbow discomfort on a scale I----------I----------I
1 Minimal 5 Moderate 10 severe

Does your elbow problem interfere with any of the following?

____ Daily Activities ____ School Activities ____Work activities ____Recreation or Sports ____Sleeping

Has your arm been evaluated by: ____Primary Care Physician ____Another Orthopedic Surgeon ____E.R. Visit

Have you had any of the following imaging studies for your elbow? Please include dates and facility, if known.

____X-ray date: _____ facility: _____ ____MRI date: _____ facility:_____
____CT scan date: _____ facility: _____ ____EMG/NCV date: _____ facility:_____
____Bone scan date: _____ facility: _____ _Other_____ date: _____ facility:_____

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

____Rest Did it help ____Yes____No ____Ice Application Did it help ____Yes____No
____Anti-inflammatory Did it help ____Yes____No ____Cortisone injection Did it help ____Yes____No
____Exercise Did it help ____Yes____No ____Acupuncture Did it help ____Yes____No
____Physical therapy Did it help ____Yes____No ____Chiropractic Did it help ____Yes____No
____Brace/Sling Did it help ____Yes____No __Other_____ Did it help ____Yes____No

How is your elbow progressing? ____Getting better ____Staying the same ____Getting worse

Have you ever had any significant arm injuries or require arm surgery in the past? ____Yes____No
If Yes, please explain and list prior dates, physicians, and any procedures: _____

_____

_____

Name_____Chart #_____ **PHYSICAL EXAM: TO BE COMPLETED BY PROVIDER**

PE: Height:_____ Weight:_____ ❍Ambulates ❍walker ❍cane ❍WC

Skin: ❍WNL ❍Lesions: _____

Pulses: ❍2+distal ❍diminished

C-Spine: ROM ❍Full ❍limited all planes ❍Tenderness to ❍Trap R L ❍Spinous process ❍WNL ❍Negative Spurling ❍Positive Spurling head to R L B ❍Causes neck pain

Hands: ❍WNL ❍LROM ❍arthritic *Wrists*: ❍WNL ❍LROM ❍+Tinels sign

Elbows:

TTP over: [ ] medial epicondyle [ ] flexor-pronator origin [ ] lateral epicondyle [ ] extensor wad [ ] radial head [ ] olecranon [ ] triceps tendon [ ] bursa

Hook test: [ ] negative (intact) [ ] positive

❍WNL ROM: Extension_____ Flexion_____ Pronation _____ Supination _____

Strength: _____/5 flexion _____/5 extension _____/5 pronation _____/5 supination

Special tests: ❍ positive for lateral epicondylitis ❍positive for medial epicondylitis

Stability: _____ varus stress (LUCL) _____ valgus stress (MUCL) _____ moving valgus stress _____ pivot shift _____ chair pushup

Neuro: _____ Tinel's at elbow _____ ulnar nerve subluxation (R / L / bilat)

PMH: □ Reviewed Intake Form □ DVT/PE Negative □ DVT/PE Positive

MEDS: _____

ALLERGIES: □ NKDA □ Positive:

PSH: _____

SH: □ Married □ Partnered □ Single

Occupation:_____ □ Retired □ Disabled

Tobacco: ETOH: THC/drugs: Activities/Hobbies: _____

_____

XRAY: _____

MRI: _____

Assessment: _____

Plan: _____

F/U_____