

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 |-----|-----|
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: _____ Date of Birth: _____ Date: _____

Tobacco Use _____ None		
<input type="checkbox"/> Cigarette	<input type="checkbox"/> Current Daily Smoker	
<input type="checkbox"/> Cigar	<input type="checkbox"/> Current Someday Smoker	
<input type="checkbox"/> Pipe	<input type="checkbox"/> Former Smoker	Interested in Quitting?
<input type="checkbox"/> E-Cig	Approx Yrs. Smoked _____	Y N
<input type="checkbox"/> Smokeless Tobacco	Quit Date _____	
	<input type="checkbox"/> Unknown	

Surgical History: _____ None _____ Other: _____			
<input type="checkbox"/> Ankle Surgery	<input type="checkbox"/> Foot Surgery	<input type="checkbox"/> Hip Surgery	<input type="checkbox"/> Knee Surgery
<input type="checkbox"/> Back Surgery	<input type="checkbox"/> Hand Surgery	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Shoulder Surgery
<input type="checkbox"/> Elbow Surgery	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Lung Surgery	<input type="checkbox"/> Wrist Surgery

Medical History: _____ None _____ Other: _____		
<input type="checkbox"/> Anesthetic Complications	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatologic Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis: A, B, C (Please Circle One)	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizure
<input type="checkbox"/> Baker's Cyst	<input type="checkbox"/> HIV	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Liver Disease	Describe _____
<input type="checkbox"/> Bursitis	Describe _____	
<input type="checkbox"/> Cancer: Describe _____	<input type="checkbox"/> Osteoarthritis	
<input type="checkbox"/> COPD or Emphysema	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Paget's Disease	

Family History: _____ None		Please Check Below for All That Apply To Your Family Members	
Please state the relationship: _____ Mother _____ Father _____ Brother _____ Sister _____ Other: _____			
<input type="checkbox"/> Anesthetic Complications	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Cancer	<input type="checkbox"/> Clotting Disorder
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dislocations	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Rheumatologic Disease
Please give specifics: _____			

Alcohol Use: _____ None	Drug Use: _____ None
Number of Drinks Per Week	<input type="checkbox"/> Marijuana _____ Cocaine
<input type="checkbox"/> Wine _____ Beer _____ Liquor	<input type="checkbox"/> Methamphetamines

Preferred Language: _____ Refused	Ethnicity: _____ Refused
<input type="checkbox"/> English _____ Other _____	<input type="checkbox"/> Hispanic _____ Non-Hispanic
	<input type="checkbox"/> Unknown

Race: _____ Refused
<input type="checkbox"/> White _____ Black _____ More Than One Race
<input type="checkbox"/> Asian _____ American Indian and Alaska Native _____ Unknown
<input type="checkbox"/> Pacific Islander and Hawaii Native _____ Other _____

Name: _____ Date of Birth: _____ Date: _____

Allergies:	_____ None	Are you allergic to Latex? Y or N	
_____ _____ _____			

Current Prescribed and Over The Counter Medications:		
Medication Name	Dosage and Frequency	Used For?

Current Preferred Pharmacy:		
Store Name	Address or Cross Streets and City	Phone Number
_____	_____	_____

CONSTITUTION: <u>None</u>	EYES: <u>None</u>	GASTROINTESTINAL: <u>None</u>	ENDO/Heme/Aler: <u>None</u>
Chills	Blurred Vision	Heartburn	Easy bruise/bleed
Weight loss	Double Vision	Nausea	Env Allergies
Fatigue	Photophobia	Vomiting	Polydipsia
Diaphoresis	Eye pain	Abdominal pain	NEUROLOGICAL: <u>None</u>
Weakness	Eye Discharge	Diarrhea	Dizziness
SKIN: <u>None</u>	Eye Redness	Constipation	Tingling
Rash	CADIOVASCULAR: <u>None</u>	Blood in Stool	Tremor
Itching	Chest Pain	Melena	Sensory Change
	Palpitations	GENITOURINARY: <u>None</u>	Speech Change
HENT: <u>None</u>	Orthopnea	Dysuria	Focal Weakness
Headaches	Leg Swelling	Urgency	Seizures
Hearing loss	PND	Frequency	LOC
Tinnitus		Hematuria	PSYCHIATRIC: <u>None</u>
Ear pain	RESPIRATORY: <u>None</u>	Flank Pain	Depression
Ear discharge	Cough	MUSCULOSKELETAL: <u>None</u>	Suicidal Ideas
Nosebleeds	Hemoptysis	Myalgias	Substance Abuse
Congestion	Sputum production	Neck Pain	Hallucinations
Stridor	Shortness of breath	Back Pain	Nervous/Anxious
Sore Throat	Wheezing	Joint Pain	Insomnia
		Falls	Memory Loss