OrthoTexas
Orthopedics & Sports Medicine

ELBOW

Was this an injury or did it occur over time?____

How long have you had this problem or what was the date of your injury?_____________________________

Where on your arm do you have the problem?____

If an injury, describe how it occurred.____

Have you had this problem before? Yes / No If yes, how was it treated?_____________________________

Rate your pain: No Pain 1 2 3 4 5 6 7 8 9 10 Absolute Pain

Describe your pain (circle all that apply):

Sharp	Aching	Stabbing	Dull	Constant Burn
Come and go	Pins & needles	Electric	Explosive	Unrelenting
Throbbing	Constant	Intermittent	Chronic	Getting better
Getting worse	Unchanged	Other:____________________		
Worse in the morning	Worse in the evening	Worse at night		

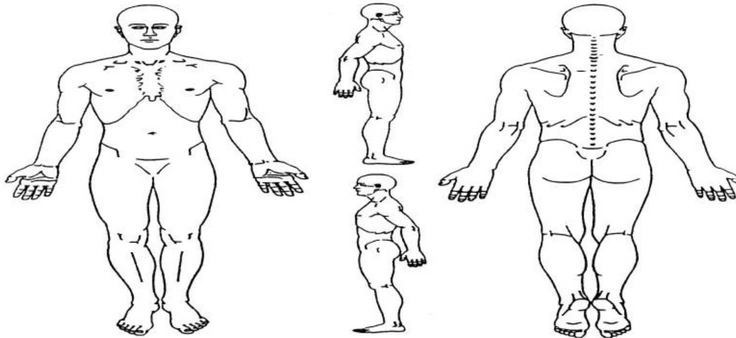
What makes your pain **worse**?____

What makes your pain **better**?____

Medications used for this problem:____

Have you had any tests for this problem? MRI / Bone Scan / X-ray / Other_____________________________

Please indicate the location of your pain with an X:



Do you have numbness or tingling? Yes / No If yes, where?_________________________________

Do you have swelling? Yes / No If yes, where?_____________________________________

Have you had instability or dislocations? Yes / No

Do you have neck pain? Yes / No

Do you have popping / catching / grinding?

Do you have weakness of grip? Yes / No

Have you had elbow surgery? Yes / No

Do you have any other problems not previously described? Yes / No If yes, please describe:___________________
____

Referring Physician:____

Other Physician(s) you have seen for this problem:______________________________________

Date(s) of work/school missed for this problem:_______________________________________

Is there an attorney involved with this problem? Yes / No If yes, please provide additional information:____________
____

Patient Name *(print)*:_____________________ Patient Signature:_____________________ Date:___________