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 | | |

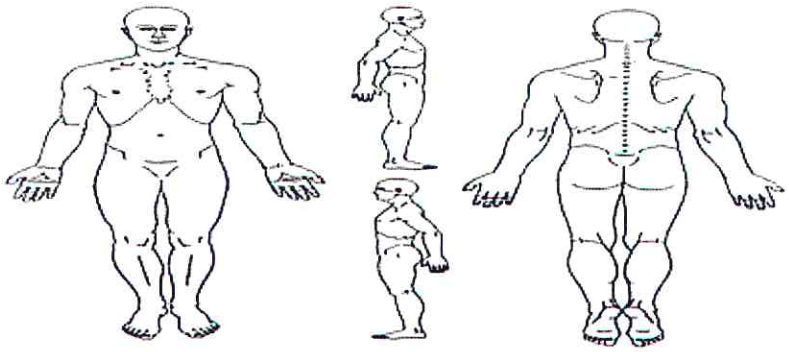
What makes your pain **worse**?_____

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:_____

*Rev. 03/2016*