THE SHOULDER CLINIC
OF IDAHO P.L.L.C.

ELBOW INFORMATION

Name: _____ **DOB:** _____

Referred By: _____

Height _____ **Weight** _____

Occupation: _____
☐Heavy Manual Labor ☐Light Manual Labor ☐Sedentary Work

Affected Elbow: ☐ Right ☐ Left
Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Briefly describe your elbow problem:

_____

_____

Did you have an injury to your elbow: ☐ Yes ☐ No **Date of Injury:** _____

If yes, briefly describe the injury: _____

_____

How long have you had the elbow problem? _____

How did the problem start? ☐ Slowly ☐ Suddenly

Rate your average pain on a 0-10 scale: _____

Have you seen any other doctors for this problem? ☐ Yes ☐ No

Have you had any previous similar episodes? ☐ Yes ☐ No

Previous Diagnostic Tests (Check All Appropriate): ☐ MRI ☐ EMG ☐ Bone Scan ☐ CT Scan ☐ X-Ray

Has your elbow been treated with any of the following?
☐Surgery ☐ Injections ☐Physical Therapy ☐Acupuncture
☐Chiropractic ☐Medications ☐ None of the above

Where is your pain located on your elbow? ☐ Back ☐ Front ☐ Bottom ☐ Top

Have you noticed any redness? ☐ Yes ☐ No
Have you noticed any swelling? ☐ Yes ☐ No
Have you noticed any warmth? ☐ Yes ☐ No
Does it hurt when you move it? ☐ Yes ☐ No
Do you have gout? ☐ Yes ☐ No
Does it cause any clicking? ☐ Yes ☐ No

Do you have any difficulties during daily activity? □ Yes □ No
Please list specific activities that are difficult: _____

_____

Do you have problems doing your routine tasks at work? □ Yes □ No
Please list specific tasks that are difficult: _____

_____

Are you unable to do your usual sports activities: □ Yes □ No
Please list specific sports that are difficult: _____

_____

Do you have difficulty with any of the following?
Holding things? □ Yes □ No
Gripping tools? □ Yes □ No
Shaking hands? □ Yes □ No
Writing? □ Yes □ No
Keyboard/Typing? □ Yes □ No
Racket Sports? □ Yes □ No
Other _____

Any other pertinent information related to your elbow pain that we should be aware of: _____

_____

_____

MEDICAL DATA SHEET

Patient Name_____**Date:**_____

Past Medical History (Mark all that apply)

○ Diabetes	○ Asthma	○ Cancer _____
○ High Blood Pressure	○ Emphysema/COPD	○ Seizures
○ Atrial Fibrillation	○ Pulmonary Embolism	○ Stroke
○ Heart Attack	○ Sleep Apnea	○ Arthritis
○ Other Heart Problem _____	○ Other Lung Problem _____	○ Rheumatoid Arthritis
○ Anemia	○ Kidney Disease	○ Osteoporosis
○ Blood Clots/Phlebitis	○ Urinary Infections	○ Gout
○ Bleeding Disorders	○ Acid Reflux/GERD	○ Fibromyalgia
○ Liver Problems	○ Stomach Ulcers	○ Chronic Pain
○ Hepatitis (type _____)	○ Anxiety	○ Reaction to Anesthesia
○ Thyroid Problems	○ Depression	○ History of MRSA Infection
○ HIV/AIDS	○ Currently Pregnant	○ Other_____

Primary Care Provider: _____

Other Providers: _____

Past Surgical History

Surgery	Year	Doctor

Current Medications

Medication Name	Strength	How many pills at a time	Times per day

Patient Name_____**Date:**_____

Allergies/Reactions to Medications, Latex, Sutures, Metal, Etc.

Allergy	Reaction

Social History

Smoking:	Never	Former (year quit_____)	Current (packs/day_____)	
Alcohol:	Never	Rarely	Occasionally	Daily

Family History

Cancer	Heart Disease	Arthritis	Reaction to Anesthesia	Abnormal Bleeding/Clotting
Explain:				

Advance Care Plan: Do you have a Living Will or Medical Power of Attorney? _____

Review of Systems (Please circle all conditions or symptoms that you *currently* experience)

General	Fevers Weight Changes Abnormal Sweats Fatigue Dizziness
Skin	Rash Infections Bruise Easily Itching Skin Growths
Eyes/Ears/Nose/Throat	Vision Loss Blurred Vision Dentures Hearing Loss Difficulty Swallowing
Respiratory	Cough Shortness of Breath Wheezing
Cardiovascular	Chest Pain Irregular Heartbeat Lower Leg Swelling
Endocrine	Sweating Excessive Thirst Excessive Urination
Gastrointestinal	Bloody Stools Constipation Diarrhea Nausea Vomiting Abdominal Pain
Urinary	Incontinence Urgency Frequency Hesitancy
Neurological	Frequent Headaches Numbness Tingling Weakness
Musculoskeletal	Fractures Joint Pain Joint Swelling Muscle Aches
Emotional	Anxiety Depression

_____

Patient/Designee Signature Date

_____

Physician/PA Signature Date

Date reviewed with patient:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____