UTAH ORTHOPAEDIC SPECIALISTS

Elbow/Wrist Questionnaire

Name:____ Date:____________

CIRCLE ONE: right handed left handed

1. Do you have a history of a deep vein clot or pulmonary embolism? ________________________
2. What happened to your elbow (or wrist)? ____

   ____
3. Which elbow (or wrist)? L or R
4. When did it happen? Date: ____________
5. How long have you had pain? Years: __________ Months:__________ Weeks:___________
6. What activities cause pain in your elbow (or wrist)? ___________________________________
7. Does your elbow slip out of joint (“dislocate”) Yes or No
8. Please draw the location of your pain on the body outlines using the following key:

Aching	Numbness	Pins and Needles	Burning	Stabbing
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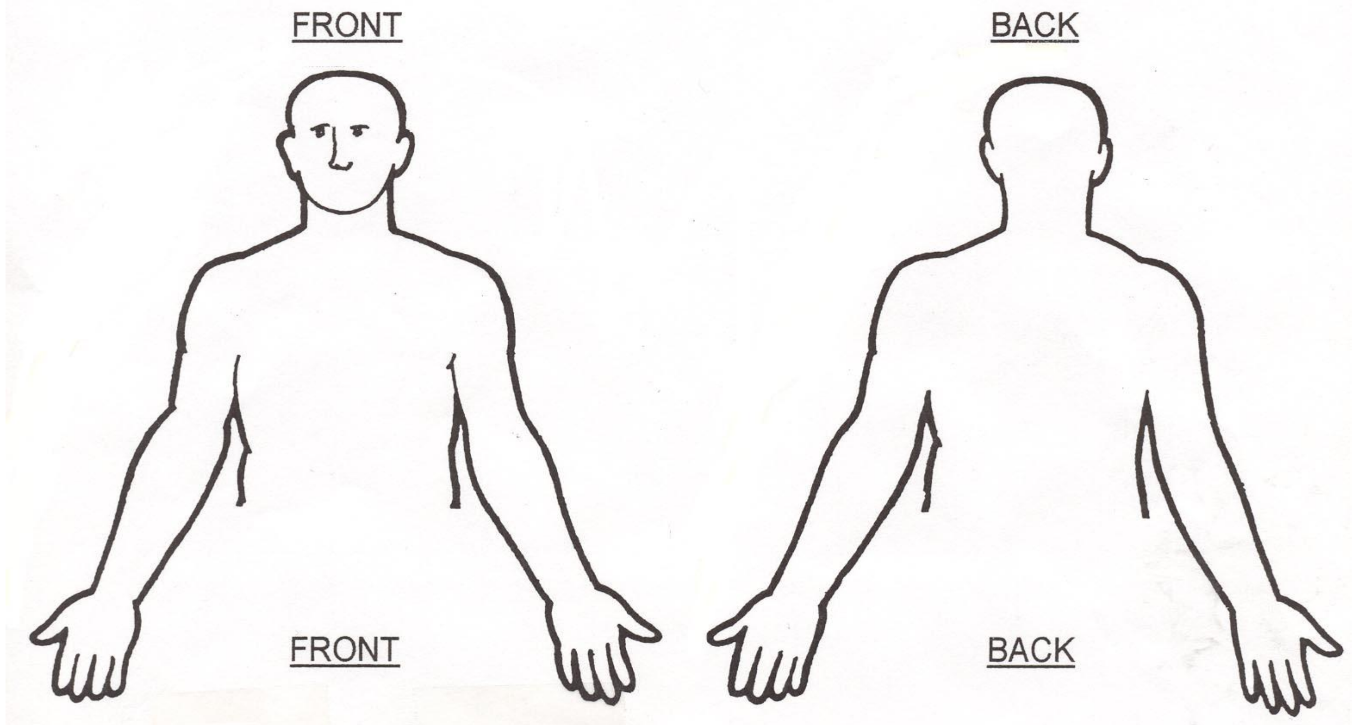

Right Left Left Right

*****SEE OTHER SIDE*****

Name:_______________________

9. What treatment have you had in the past (include physical therapy)? ____________________
10. Are you (please circle) better, worse, or the same since your treatment began?_____________
11. Do you have pain in your elbow (or wrist) at night? Yes or No
12. Have you ever had any surgery done on your elbow (or wrist)? Yes or No
13. Have you ever had a cortisone injection in your elbow (or wrist)? Yes or No

    If so, how many times? _________________

    When were the shots given? Date:_______________
14. What athletic activities do you participate in? Please list: ____________________________
15. Are you taking any pain medications? If so, please list: ______________________________
16. How many pain pills do you take each day? ___________
17. Are you ALLERGIC to any medications? If so, please list: __________________________
18. Who referred you to this office? ____
19. How bad is your pain today (mark line with an **X**)?

____

No pain at all Pain as bad as it can be

19. Does your elbow feel unstable (as if it were going to dislocate)? Yes or No
20. How unstable is your elbow (mark line with an **X**)?

____

Very Stable Very **Un**stable