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ORTHOPAEDIC SURGERY AND SPORTS MEDICINE

UCLA Health

New Elbow Patient Intake Questionnaire

PLEASE PRINT

Please provide your referring physician's name, address (if known, if not list the city) and phone number (if known):

_____

_____

_____

Are you Right handed or Left handed or ambidextrous? (please circle one)

What problem brings you in today (circle **ONE** item from each line below)?

Left Elbow Right Elbow Both (which side is worse?)_____

Pain Dislocation Unstable joint Decreased motion Other: _____

How long has your elbow hurt? _____ (how many days, weeks, months, or years?)

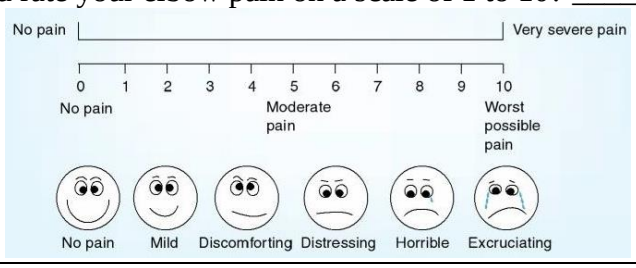
Was this elbow problem the result of a specific injury or no specific injury?

(Generally injuries that occurred many years ago and did not causing constant disability can be considered no specific injury)

☐Yes, my injury was: _____

☐No specific injury

How severe would you rate your elbow pain on a scale of 1 to 10? _____ (refer to scale below)

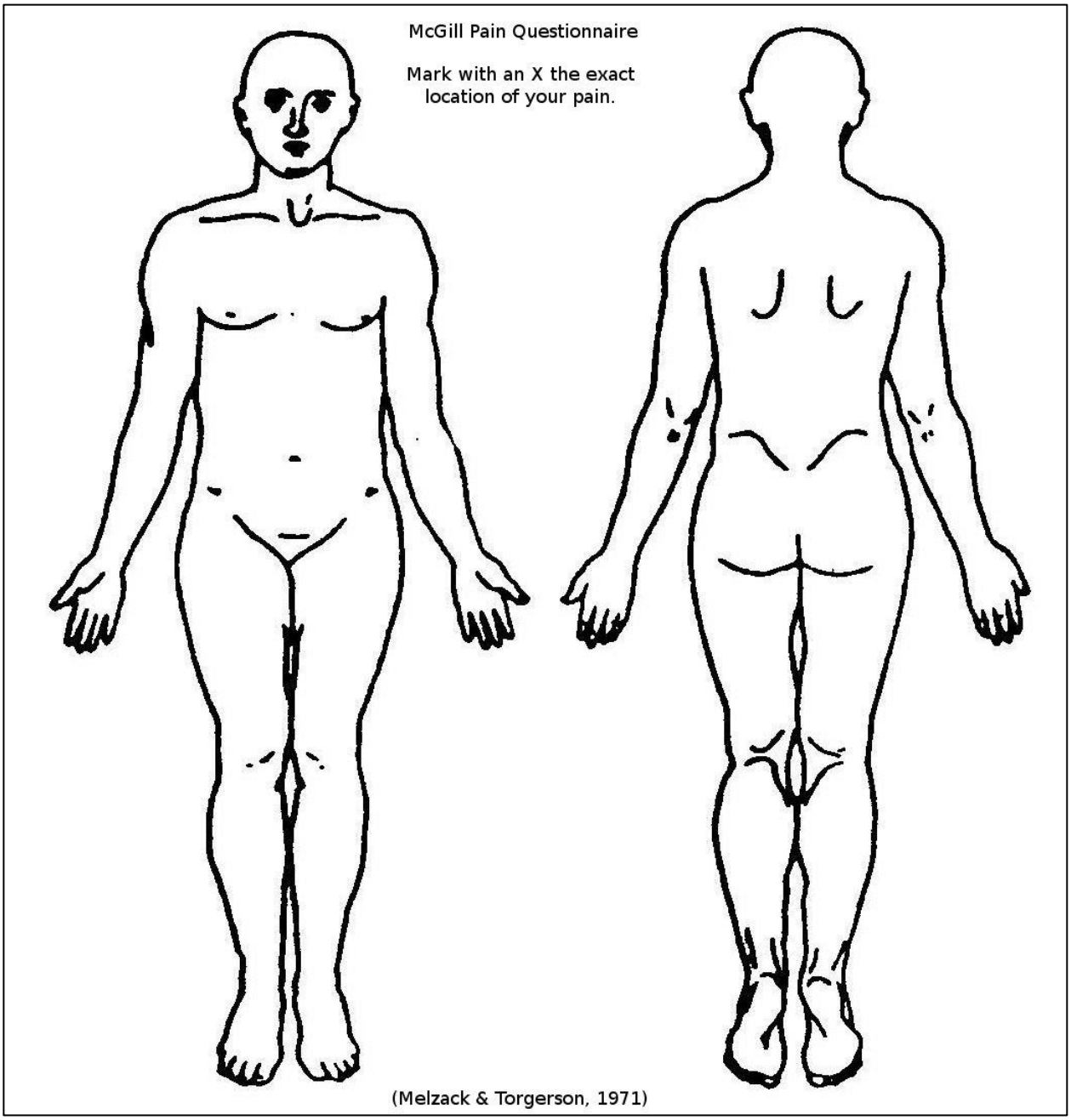


How would you rate your elbow <u>today</u> as a percentage of normal (0% to 100% scale with 100% being normal)? _____%

Circle any previous treatments: Physical Therapy Injection Surgery

Have you taken NSAIDs? ☐Yes ☐No Did they help with your pain? ☐Yes ☐No

Examples of NSAIDs: ibuprofen (advil, Motrin), Naproxen (Naprosyn/Aleve), Diclofenac (Voltaren), Meloxicam (Mobic)



Please check all that apply:

CARDIOVASCULAR
- θChest Pain
- θIrregular heart beat
- θPoor circulation
- θDizziness
- θRapid heart rate
- θSwelling of ankles

CONSTITUTIONAL
- θChills/fever
- θFainting
- θHeadache
- θLoss of sleep
- θUnplanned weight loss
- θLoss of appetite
- θNight sweats

ENDOCRINE
- θRapid weight loss/gain
- θIntolerance to warm room
- θMultiple broken bones
- θCessation of menstrual periods
- θExcessive hunger/thirst
- θLoss of libido
- θThyroid disease
- θDiabetes
- θPregnant?
- θLow Vitamin D

HEMATOLOGIC
- θSwollen lymph nodes
- θEasy skin bruising
- θProlonged bleeding from cuts, tooth extractions
- θBlood clots in the past?
- θSickle cell disease

IMMUNOLOGIC
- θAutoimmune disease
- θRheumatoid arthritis
- θPsoriasis
- θAnkylosing spondylitis
- θAre you HIV positive?
- θJoint infections in the past
- θBone infections in the past
- θChronic infections anywhere in the body

INTEGUMENTARY
- θ Skin rashes or eruptions
- θ Bruises
- θ Redness
- θ Draining wounds

MUSCULOSKETAL
- θMultiple joint pains
- θLower back pain
- θNeck pain
- θBroken bones
- θJoint replacements

NEUROLOGIC
- θ Fainting
- θ Headaches
- θ Numbness of arms or legs
- θ Electric pain in arms or legs
- θ Seizures
- θ Tingling of hands, feet, arms or legs
- θ Bowel incontinence
- θ Bladder incontinence (spilling urine abnormally)

PSYCHIATRIC
- θAnxiety
- θDepression
- θPanic attacks
- θRestlessness
- θBipolar disease
- θAttempted suicide in the past

RESPIRATORY
- θCough
- θShortness of breath
- θWheezing
- θCoughing up blood
- θPneumonia

DENTAL:
- θDental infections
- θGum disease

Do you have any **medical problems**? (Example: Diabetes, Cancer, Heart attack, Stroke, high blood pressure, gastroesophageal reflux, autoimmune disease, Rheumatoid arthritis, Thyroid problems, Marfans, Ehlers Danlos)

_____

_____

_____

Have you ever had **surgery** in the past? (Example: Gall bladder removed, appendix removed, tonsils removed, broken bone surgical repair, pacemaker implanted, cancer surgery, spine surgery)

_____

_____

_____

Current Medications:

Name of Medication	Dose	How often do you take it? Ex: twice a day, once a week

Allergies to medications and type of reaction:

_____

_____

Family History of Medical Problems: If yes, explain

- Father: ❑Yes ❑No
- Mother: ❑Yes ❑No
- Grandparents: ❑Yes ❑No
- Siblings: ❑Yes ❑No

Social History:

Do you smoke? ☐Yes ☐No If yes, how many packs per day? _____
(includes cigars/pipes/vaping)

Do you drink alcohol? ☐Yes ☐No If yes, how many drinks per week do you drink? _____

Do you use any other drugs? ☐Yes ☐No If yes, what substances do you use? _____
How often do you use these substances? _____

Occupation: _____

With whom do you live currently (circle one)?

Alone Parent(s) Spouse (significant other) Homeless Other: _____

PLEASE LEAVE THIS SPACE BLANK
(for office use only)

PE:

PLAN: