Shoulder and Elbow History Form

Mohit N. Gilotra M.D.

Patient Name/ Label:		Gender : M F	Date:
		PCP:	
DOB:	Age:	Referring Physician: Address:	
Height:	Weight:		
Occupation:			

Hand Dominance: (Circle one)		Right	Left
Affected Extremity:	Shoulder :	Right	Left
	Elbow:	Right	Left

Chief Complaint: ____

Circle any that apply :	Pain	Loss of Motion	Dislocation (If so how many) ________

Duration of symptoms: ___________________________ Date of injury: _________________________

Work Related: Yes No

Location of pain: ____

Description of pain: Dull Sharp Burning

What makes the pain worse?

____

What improves the pain?

____

Treatment:	Circle Yes or No	Did it help?
Anti-inflammatory	Yes No	
Physical Therapy	Yes No	
Injections	Yes No	
Narcotics	Yes No	

Any Recent visits to the E.R. for this problem:	Yes	No
Previous Surgeries for this problem:	Yes	No

Procedure and Date : ____

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Imaging Studies	Circle: Yes or No	Date	Results
Plain X-rays	Yes No		
MRI	Yes No		
CT Scan	Yes No		
Other	Yes No		

Past Medical History: (ex: diabetes, hypertension, heart disease, thyroid condition, rheumatoid arthritis, asthma)

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Past Surgical History:

Procedure	Date

Physician Signature:_____________________________________ Date and Time: _____________________