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CENTER FOR
ORTHOPEDIC
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Patient Name _____

Date _____

ELBOW PAIN SURVEY

Dominant Hand: Right Left
 Which elbow is bothering you? Right Left Both
 What is the problem with your elbow? _____

When did it start? _____ Suddenly Gradually
 Is your problem getting worse better staying the same?

Is this work-related? Yes No Unsure

Is this the result of an injury? Yes No

If yes, please describe how it happened. _____

Do you have pain in your elbow? Yes No Is your pain: constant comes and goes

Describe your pain: Dull Sharp Throbbing Tight Aching Burning Numbness Tingling
 Which best describes you pain? None Mild Moderate Severe

Is your elbow comfortable with your arm at your side? Yes No

Does your elbow allow you to sleep comfortably? Yes No

Pleas rate your pain on the following scales

When it is at its worst	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain ever
At rest	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain ever
Lifting a heavy object	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain ever
When performing a repetitive task	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain ever
At night	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain ever