History Of Present Illness

Please complete <u>ALL</u> questions. This information is necessary for the physician to evaluate and treat your condition.

Name:_____ Date:_____ Date of Birth:_____

Please circle if this visit is **WORK RELATED, AUTO RELATED** or **POST OP**

Please answer the following questions in reference to **Body Part #1:**

Primary care physician: _____

List other providers (including ER) you have seen for this:_____

Where is your pain located?_____

Where (if any) have x-rays or MRIs been taken? _____

When did your symptoms/injury occur?_____

Is your pain the result of an injury? (Circle) **YES** **NO**

If yes, How you were injured?_____

_____

_____

Where did the injury occur?_____

Rate **severity** of pain today (Mild) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

How **frequent** are your symptoms? *Constant* *Intermittent* *Rare* *Occasional*

Are your symptoms: *Improving* *Worse* *Stable*

Is your pain: *Aching* *Sharp* *Throbbing* *Dull* *Burning*

What aggravates your pain?

_____

What relieves your pain?

_____

Do you have any of the following symptoms?

Bruising *Instability* *Limp* *Night Pain* *Numbness* *Popping* *Stiffness* *Swelling*