

# HISTORY OF PRESENT ILLNESS

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_

**VITALS:** Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_

Did your Doctor send you here today? Yes or No Name of Doctor: \_\_\_\_\_

Have you had X-Rays, MRI, CT or other tests for this problem? Yes or No

Do you have them with you? Yes or No

## **CHIEF COMPLAINT:**

Date of first symptom or injury: \_\_\_\_\_

How did injury happen? \_\_\_\_\_

**DOMINANT:** (Are you left or right handed) RIGHT OR LEFT

## **HISTORY OF PRESENT ILLNESS:**

1. Where is your pain? \_\_\_\_\_ LEFT or RIGHT  
(Examples: Right Index finger or from the knee down to ankle)

2. Is it: Sharp Burning Dull Aching

3. Is it: Mild Moderate Severe

4. When does your pain occur? Morning Night Constant

5. Is it: Getting Better Getting Worse Staying the Same

6. What makes it better? \_\_\_\_\_

7. What makes it worse? \_\_\_\_\_

8. Is there any: Swelling Numbness