Northern Rockies Orthopaedics

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HISTORY OF PRESENT ILLNESS

DATE: _____ AGE: _____ Male Female

NAME: _____ Are you Left or Right handed? (circle one)

Did your doctor send you here today? Yes or No Name of doctor: _____

Date and time of injury or onset of problem: _____

Where were you when injury occurred: _____

Have you had x-rays, MRI, CT or other test for this problem? Yes or No

Do you have them with you? Yes or No

Have you been to the Emergency Room for this problem? Yes or No

If yes: Date seen: _____ Where were you seen?
- ❑ Community
- ❑ St. Patrick Hospital
- ❑ Other: _____

Name of Employer: _____ Occupation: _____

Is this a work-related injury? Yes or No **(If no, please go on to Chief Complaint.)**

Date Last Worked: _____

Are you on light duty for this injury? Yes or No Describe: _____

Is an attorney involved in your injury? Yes or No Name: _____

CHIEF COMPLAINT:

Reason you are being seen today: _____

HISTORY OF SYMPTOMS:

1. Where is your pain or problem? _____
2. When did it start?_____
3. Is it: Sharp Burning Dull Aching Throbbing
4. Is it: Mild Moderate Severe
5. When does it occur? Morning Night Constant Intermittent After Exercise During Exercise
6. Is it: Getting Better Getting Worse Staying the Same
7. Describe what makes it better: _____
8. Describe what makes it worse: _____
9. Do you have any of the following: Swelling Numbness Bruising Tingling