 *Bruce D. Smith, M.D - John E. Winter, M.D. - Michael J. Shannon, M.D.*

 *Bret R. Winter, M.D. - Gary I. Molk, D.O. – Daniel Kisicki, M.D.*

 *Lindsay Tully, PA-C - Kelli A. Chambers, PA-C*

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient’s History of Present Illness**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 R L L R

 

1. Please tell us **where** your pain is located. (Shade the area on the diagram)

2. Does your pain **radiate** or **move** to other locations? (Indicate with arrow)

3. On a scale of 0-10, please **rate** your pain.

 0 = no pain 10 = Pain that would send you to the ER

0 1 2 3 4 5 6 7 8 9 10

 At best: \_\_\_\_\_\_\_ At worst: \_\_\_\_\_\_\_

4. What makes your pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. What makes your pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Do you have sensations of **POPPING**, **LOCKING**, or **GRINDING**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If yes, is it painful when these things occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Do you have any **WEAKNESS** or sensations of it **GIVING WAY**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Please choose from the following list of terms to **describe the pain**

 Sharp Dull Aching Stinging

 Rubbing Burning Pulling Pressure

 Tearing Cramping Stabbing Stretching

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Do you have any **numbness** or **tingling** near the painful area? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Does the pain wake you from sleep at night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Do you need a note for work or School? **Yes No**

12. Do you need a medication refill? **Yes No** I am taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Preferred Pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_