



Hess Orthopaedics and Sports Medicine, PLC

History of Present Illness Form

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Primary Care Physician: _____ Referring Physician: _____

Height: _____ Weight: _____ Right Handed Left Handed


Chief Complaint: What is the reason for your visit today? Please include right, left, and bilateral (if applicable).

Duration: How long have you had pain/symptoms?

Was there an injury? Yes No If Yes, date of injury: _____ Describe injury: _____

Job related? Yes No Auto accident? Yes No If yes, State: _____

Location: Where is the location of the pain?

Severity: What is your pain level? Please circle: 

Quality: What is the quality of your pain? Dull Sharp Electrical Burning
 Pins and Needles Other: _____

Timing / Context: How long do symptoms last?
When do symptoms occur (time of day, after activities, etc.)?

Modifying factors: What makes the pain feel better?
What makes the pain feel worse?

Associated signs/symptoms: Is there any swelling, redness, etc?

List any prior treatments and when/where performed (examples: surgery, braces, physical therapy, injections, medications):

Have you had any of the following studies previously? Circle if applicable and list when/where performed:
MRI CT Scan EMG needle study Bone scan Ultrasound Blood work Other (explain): _____

For Office Use Only

Provider:

Reviewed on: