Precision Orthopaedics – History of Present Illness/Injury

Name: ____ **Date:** _____________________________

Which body part are you being seen for today? (Please Circle **ONE**) Side:

Knee Hip Shoulder Rt Lt Both

Other: ____

Onset of Pain: (When did injury occur/When did pain start): ____

Does the pain radiate? ______ Yes ______ No

If yes, where does the pain radiate: ____

On a scale of 1-10 (10 being worst), what is your: Current Pain Level _________ ; Worst Pain Level: ____________

How would you describe your pain? (Please circle all that apply)

Ache Burning Discomfort Dull Numbness Sharp Shooting Stabbing Throbbing

Other: ____

Was there an injury that caused your pain? ______ Yes ______ No

If yes, how did the injury occur? ____

____

Which of the following aggravates your pain? (Please circle only those that apply)

Stairs Kneeling Lifting Squatting Sitting Standing Pushing

Other: ____

Have you tried any of the following?

Physical Therapy: ___ Yes ___ No If "yes", did it give relief? ___ Yes ___ No

Injections (Cortisone/Steroid) ___ Yes ___ No If "yes", did it give relief? ___ Yes ___ No

Other Injections:
(Euflexxa, Supartz, Synvisc) ___ Yes ___ No If "yes", did it give relief? ___ Yes ___ No

Pain Medication: ___ Yes ___ No If "yes", did it give relief? ___ Yes ___ No

NSAID's :
(Ibuprofen, Motrin, Aleve) ___ Yes ___ No If "yes", did it give relief? ___ Yes ___ No

Surgery: ___ Yes ___ No If "yes", when & where? ___________________________
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