



Barrington Orthopedic Specialists

HISTORY OF PRESENT ILLNESS

Patient Name: _____ Date: _____

Height: _____ Weight: _____ Age: _____ Shoe Size: _____ Which hand do you write with?
Right Left Ambidextrous

Family Physician: _____ Physician Phone: _____

Physician Address: _____

Referring Physician: _____ Physician Phone: _____

Physician Address: _____

For what part(s) of your body are you seeing the doctor today? _____

What was the date of injury or when did your symptoms start? _____

Please describe the injury or how the symptoms started: _____

Please check any of the following symptoms that you have:

- Pain Stiffness Tingling Numbness Night Awakenings Instability Swelling Warmth
- Clicking Popping Catching Locking Deformity Bow legged Knock kneed Weakness
- Burning Incontinence Limp Mass Other: _____

What activities, movements, or treatments have made your pain better? _____

What activities, movements, or treatments have made your pain worse? _____

Have you had any previous surgeries or hospitalizations for this condition? _____

Have you had any tests performed for your condition? (EMG, MRI, X-ray, etc.) _____

Did the injury happen at work? Yes _____ No _____

 If yes, have you filed a Workers Compensation claim? Yes _____ No _____

Did the injury happen in a motor vehicle accident? Yes _____ No _____

If you have an attorney for this condition, provide name and phone #: _____



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Mark the appropriate area on the diagram where you feel the described sensation.

PAIN



NUMBNESS



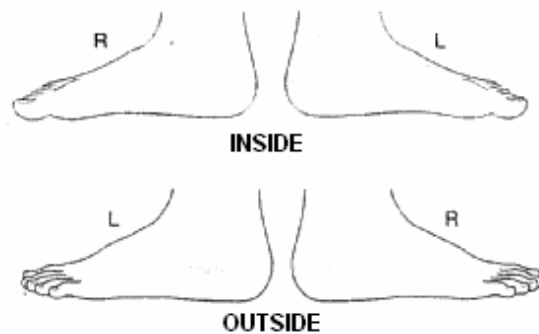
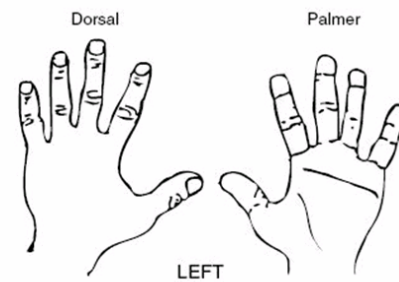
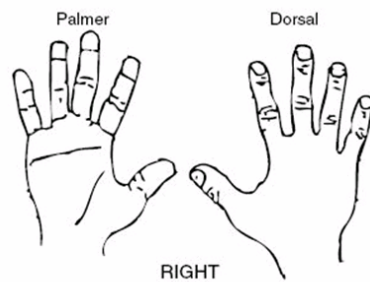
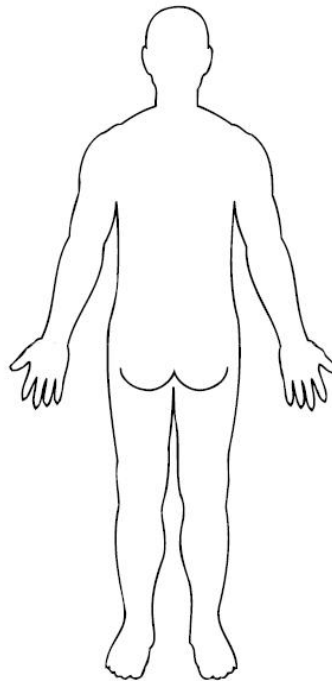
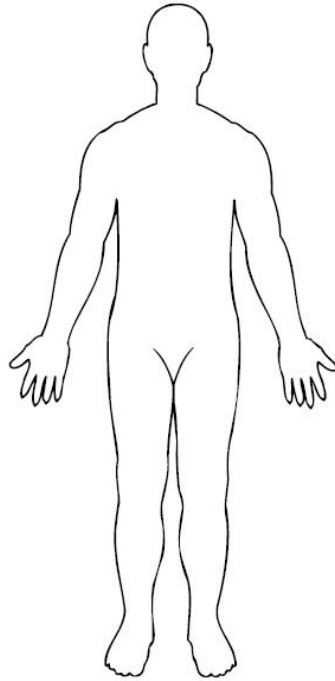
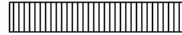
PINS & NEEDLES



BURNING SENSATION



STABBING SENSATION



I have reviewed the above information and confirm that it is current and correct to my knowledge.

Signature: _____

Date: _____