

NAME: _____ DATE: _____

CHIEF COMPLAINT:

What is the main reason for your visit today? (Describe your problem in detail)

HISTORY OF PRESENT ILLNESS

(LOCATION) 1. Location of the problem? _____

(SEVERITY) 2. On a scale of 1-10, with 10 being the most **severe**, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

(TIMING) 3. When did you first notice the problem? _____

(MODIFYING FACTORS) 4. Does anything help or make the problem worse? _____

(DURATION) 5. How long does the problem last? _____

(ASSOCIATED SIGNS) 6. Is anything else occurring at the same time?
YES NO If yes, please explain? _____

7. Does the problem interfere with your normal functions?
YES NO If yes, please explain? _____