MAYFIELD History of Present Illness

PM&R Patient

Today's Date______/_______/______ **Please use black or blue ink - Please print**

Patient Name	Date of Birth

History of Present Illness

Indicate the location(s) and side(s) of your body where the symptoms occur.

☐ neck	☐ left	☐ right	☐ hip	☐ left	☐ right
☐ upper back	☐ left	☐ right	☐ buttock	☐ left	☐ right
☐ middle back	☐ left	☐ right	☐ upper leg	☐ left	☐ right
☐ lower back	☐ left	☐ right	☐ shin/calf	☐ left	☐ right
☐ shoulder	☐ left	☐ right	☐ hand	☐ left	☐ right
☐ upper arm	☐ left	☐ right	☐ foot	☐ left	☐ right
☐ elbow	☐ left	☐ right	☐ toes	☐ left	☐ right
☐ forearm	☐ left	☐ right			

☐ Other____

Describe the symptoms you are experiencing: ____

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These symptoms have been present for

☐ 1-7 days ☐ 8-14 days ☐ 14-21 days
☐ 1 month ☐ 2 months ☐ 3 months
☐ 6 months ☐ 9 months ☐ 12 months
☐ greater than 12 months

These symptoms started on (give specific date, if known) ________________________________

Has there been any change in your daily activities due to these symptoms? ☐ no ☐ yes
Since what date have you been unable to perform your daily routine? ___________________________

Mayfield provider signature ____ **Date**________________