Medical History - continued

Describe Your Major Complaint

Pains are:

☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

How Often?

Does pain radiate?

◯ Yes ◯ No

Date when pain or problem started?

What activities aggravate your condition/pain?

Sleeping Posture

◯ Side ◯ Stomach ◯ Back

What activities lessen your condition/pain?

Is the condition worse during certain times of the day? Please explain:

Have you seen other doctors for this condition?

Is the condition getting progressively worse?

Do you use any home remedies?

Is this condition interfering with:

Work ◯ Yes ◯ No

Sleep ◯ Yes ◯ No

Routine ◯ Yes ◯ No

Other

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