FREMONT ORTHOPAEDICS PC

Cory J. Lamblin, MD
Ben S. Francisco, MD

Answers are confidential. Any question you prefer not to answer, simply leave blank

Patient Name _____ Age _____ ☐Male ☐Female

Height_____ft_____in Weight _____ lbs | *(Staff) BP _____ Pulse _____ O2 Sat _____ Resp_____*

Do you have a referring physician/provider? ☐No ☐Yes _____

What is the main purpose of your visit? _____

How long has this problem been present? _____ ☐Days ☐Weeks ☐Months ☐Years

What Body Part(s) Involved?

Neck ☐	**Shoulder ☐R ☐L**	**Arm/Elbow ☐R ☐L**	**Wrist ☐R ☐L**	**Hand ☐R ☐L**	**Finger(s) ☐R ☐L Thumb IF MF RF SF**
Back ☐ Pelvis ☐	**Hip ☐R ☐L**	**Knee ☐R ☐L**	**Ankle ☐R ☐L**	**Foot ☐R ☐L**	**Toe(s) ☐R ☐L**

❖Please indicate which best describes how your problem started:

☐Injury Not at Work Date: _____/_____/_____

How did it happen?_____

☐Injury at Work Date: _____/_____/_____

How did it happen? _____

☐No Injury Date: _____/_____/_____ (Onset was: ☐Sudden ☐Gradual)

What do you think caused this? _____

❖Please check the box below which best describes your problem:

The **Pain** is: **☐Constant ☐Intermittent-comes and goes**
Since your problem started has it been changing for the**?** **☐Better ☐Worse ☐Unchanged**

Severity: ☐Mild ☐Moderate ☐Severe ☐Extremely Severe
Quality: ☐Sharp ☐Dull ☐Aching ☐Burning ☐Electrical ☐Radiating
Associated Symptoms: ☐Swelling ☐Numbness ☐Weakness

Does your pain inhibit/affect **sleep? ☐No ☐Yes-How often? _____**

Is there anything that *worsens* the symptom(s)?_____

Is there anything that *improves* the symptom(s)? _____

Have you taken medication(s) for your current problem**? ☐No ☐Yes, Which? _____**

Have you participated in any **treatment(s)** for your current problem**? ☐No ☐Yes**
❖Please mark ALL that apply❖: ☐Physical Therapy ☐Bracing ☐Injection(s) ☐Activity modification ☐Chiropractic ☐Massage ☐Injection ☐Ibuprofen/Aleve/Motrin ☐Acupuncture

Patient/Parent Signature_____ Date: _____/_____/____18_____

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Patient Name _____

Allergies: Do you have any medical allergies? ☐ None ☐YES-please list: ☐Penicillin ☐Amoxicillin ☐Sulfa

_____

Medications: ☐None Please list with dosage when possible: 1._____

2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____

Review of Systems: Do you have or have you ever had any of the following health problems?

Please check any that apply or mark None. Explain Details/Comments/Date(s) In Space Provided Below:

Have you had the ***current problem*** previously? ☐ NO ☐YES _____

Review of Systems: _____

CON: ☐**None** ☐Weight loss ☐ Loss of appetite ☐Fever ☐ Cancer ☐ Other _____

MS: ☐**None** ☐Orthopedic Surgery ☐ Fracture(s) ☐ Bone Tumor ☐Other _____

EYE: ☐**None** ☐Glasses/Contacts ☐ Cataracts ☐Glaucoma ☐Blindness ☐Other _____

ENT: ☐**None** ☐Hearing loss ☐Vertigo ☐ Other_____

CV: ☐**None** ☐High Blood Pressure ☐ Heart Attack ☐ Blood Clot ☐Other _____
☐Atrial Fibrillation/Abnormal Rhythm ☐Pacemaker ☐Fainting/Falls

RP: ☐**None** ☐Asthma ☐ Sleep Apnea ☐ Pneumonia ☐ COPD ☐Other _____

GI: ☐**None** ☐Ulcers ☐Heartburn ☐Hepatitis ☐Bloody Stool ☐Other _____

GU: ☐**None** ☐Kidney disease ☐Painful Urination ☐ Kidney stones ☐Other _____

INT: ☐**None** ☐Melanoma ☐Psoriasis ☐ Eczema ☐ Rash ☐Other _____

N: ☐**None** ☐Migraines ☐Seizures ☐ Stroke/TIA ☐ Nerve compression ☐Other _____

PSY: ☐**None** ☐Depression ☐Anxiety ☐Bipolar ☐Sleep Disorder ☐ADHD ☐Other _____

HEM: ☐**None** ☐Bleeding or Clotting Disorder ☐Easy Bruising ☐Other _____

Details/Other: _____

(*Con-Constitutional, MS-Musculoskeletal, ENT-Ears, Nose, Throat, CV-Cardiovascular, RP-Respiratory, GI-Gastrointestinal, GU-Genitourinary, INT-Integument/Skin, N-Neurologic, PSY-Psychiatric, HEM-Hematologic)

Family History of: ☐Bleeding/Clotting Disorder ☐Arthritis ☐Other_____

Prior **Surgery**? ☐No ☐Yes ➔ Type/Date(s)_____

_____

Nicotine Use? ☐No _____Packs/Day _____ Years ☐Oral Tobacco Frequency _____

Alcohol Use? ☐No ☐Occasional ☐Weekly ☐Daily _____Drinks/Day

If you are interested in obtaining help in decreasing your consumption of any substance please inform staff or physician.

Marital Status: ☐ Married ☐Single ☐ Divorced ☐Widowed ☐Civil Union/Committed relationship

Occupation/Employer: _____ ☐Retired ☐Student ☐Unemployed ☐Disabled

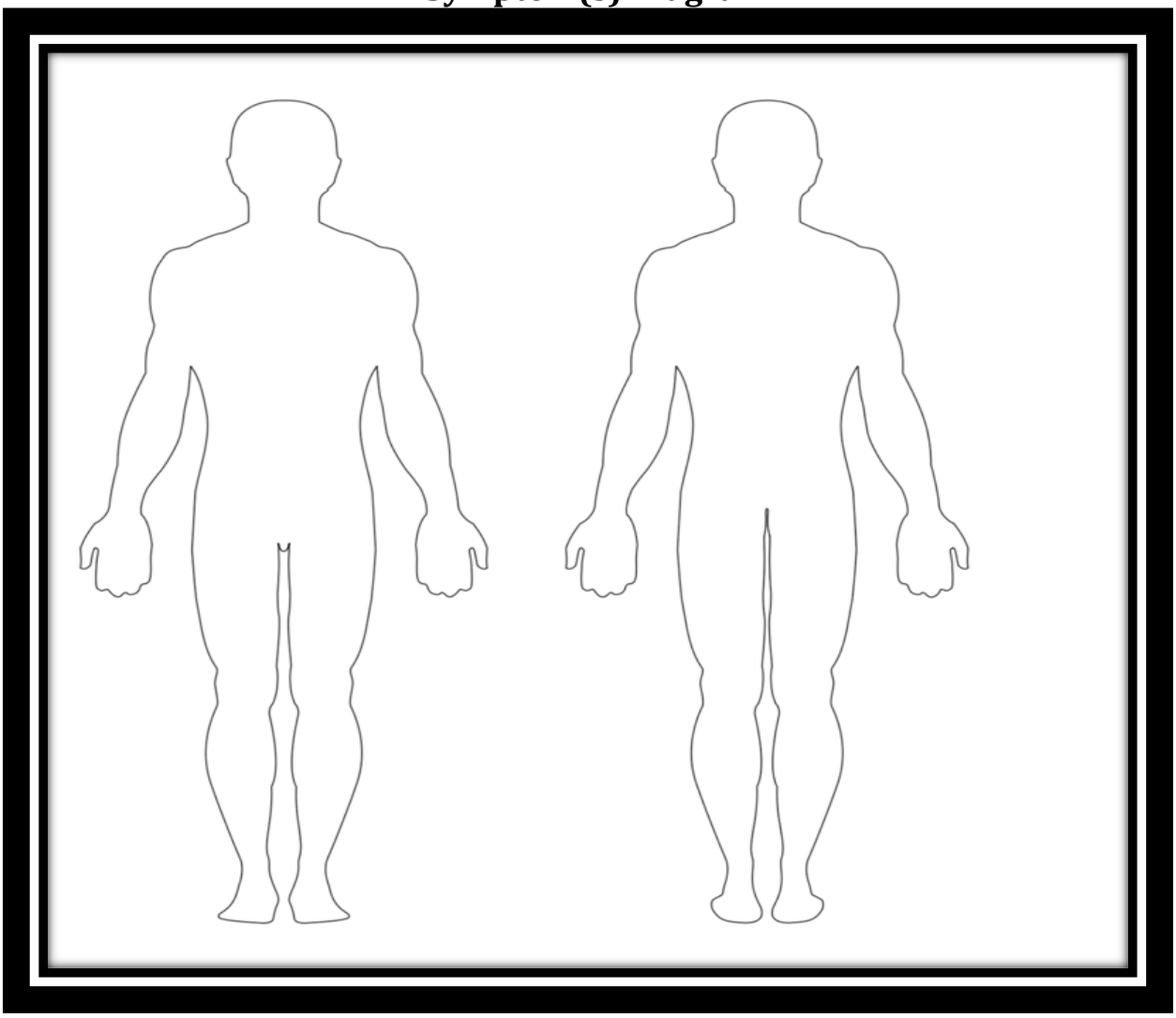
Additional Comments:_____

Patient Signature _____ Date _____/_____/_____18____

Physician Signature_____Date _____/_____/_____18____(All pages reviewed)

Patient Name: _____

Symptom(s) Diagram



R FRONT L L BACK R

Please mark areas where you experience the following symptoms:

XXX	Pain or Tenderness
o o o	Numbness/Paresthesia (tingling/decreased sensation)
\ \ \	Burning/Stabbing/Electrical