RUSSELL M. LAFRANCE MD

Orthopedic Surgeon & Sports Medicine

Name:____Date of Birth______________

Ht:______ Wt:______ BP:_______ P:_______ R:_______

Who is your primary care doctor:_______________________Who referred you to us:__________________

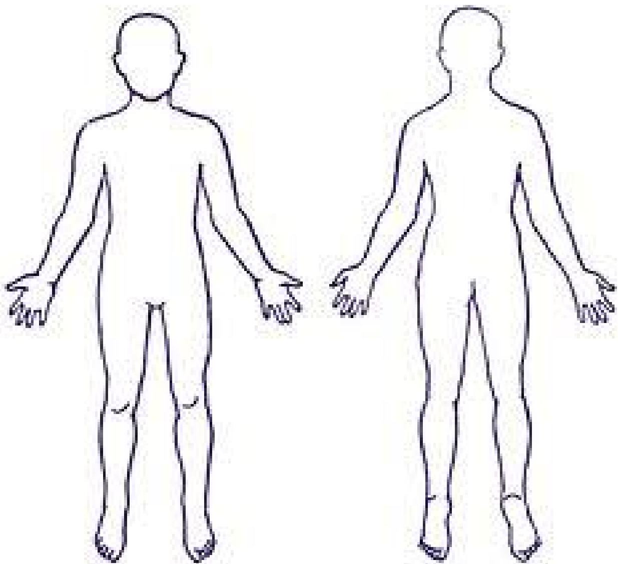
How long have you had the pain?_____________

Was this a result of an injury? (circle one) **Yes or No** If so, what was the date if the injury:________

If so is this a workman's compensation injury (circle one) **Yes or No** or no fault (circle one) **Yes or No**

Are you currently working? (circle one) **Yes or No**

Dominate Hand **LEFT** or **RIGHT**



Pain Scale

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Have you had any of the following treatments? (Please circle)

NSAID Year________________
Was it helpful?

Physical Therapy – Year ________________
Was it helpful?

Chiropractor _ Year________________
Was it helpful?

Injections - Year________________
Was it helpful?

Acupuncture – Year____________________
Was it helpful?

Massage - Year______________________
Was it helpful?

Surgery – Year _______________________
Was it helpful?

	Do you have pain with…		Are you better with…		Have you had any of the following?
	Lifting		Lifting		XRays
	Bending		Bending		MRI
	Sitting		Sitting		CT Scan
	Walking		Walking		CT Myelogram
	Laying down		Lying down		Bone Scan
	Activity in general		Activity in general		EMG
	Nothing in particular		Nothing in particular		Stress Echo
	Stairs				

Are you allergic to any medications? (circle one) **Yes or No**

If so please list:____

Are you allergic to contrast dye of iodine? (circle one) **Yes or No**

When was your last Flu Shot: __________ Pneumonia shot:__________ Hepatitis B shots:______________

Women: Breast Exam _____________ Pap /Rectal____________________

Men: Prostate/Rectal_______________________

NAME:____ Date of Birth________________

Review Of Systems

Place a check in the box if you have any of these symptoms.

	Fever or Chills		Chest Pain		Blood in Stool
	Weight Loss		Heart Palpations		Change in Bowel Habits
	Double Vision		Shortness of Breath		Urinary Urgency
	Blurred Vison		Skin Issues		Urinary Incontinence
	Changes in hearing		Rashes		Blood in Urine
	Nose Bleeds		Intolerance to Heat		Depression
	Coughing up Blood		Intolerance to Cold		Anxiety

Medical History

Place a check in the box if you have any of the following conditions.

	MRSA infections		COPD		Kidney Stones
	Hepatitis		Asthma		Kidney Disease
	DVT (blood clot)		Heart Attack		Meningitis
	Pulmonary Embolism		Heart Murmur		Epilepsy
	Alcoholism		High Blood Pressure		Headaches
	Arthritis		High Cholesterol		Seizures
	Bleeding Disorders		Rheumatic Fever		Stomach Ulcers
	Cancer		Diabetes		Gastric Reflux
	Stroke		Thyroid Disease		Tuberculosis
	Depression		Anxiety		Bipolar Disorder

Do you have a history of any other medical problems not listed above? (circle one) **Yes or No**

If so please list:____

Have you had any surgeries? (circle one) **Yes or No**

If so please list:

Type of Surgery	Date of Surgery	Location of Surgery

Have you needed to be hospitalized for any reason? (circle one) **Yes or No**

Type of Illness	Date of Hospitalization	Location of Hospital

Have you ever required a blood transfusion? (circle one) **Yes or No**

If yes please explain: ____

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Family History

Please fill in the following table regarding the health of your parents, grandparents, brothers, sisters, and children. If you cannot answer the question, please indicate "don't know". If you do not have surgery, please mark "n/a".

Health Problems DOB

Father:____/________

Mother:____/________

Your Children: How many total?:_______

Health Problems DOB Health Problems DOB

Boys:____________________/_____ Girls: ____________________/_____

____________________/_____ ____________________/_____

____________________/_____ ____________________/_____

Your Siblings: How many total/: _______

Health Problems DOB Health Problems DOB

Brothers:____________________/_____ Sisters: ____________________/_____

____________________/_____ ____________________/_____

____________________/_____ ____________________/_____

Social History

Are you married, single, divorced, or widowed? ____________

Do you live alone (circle one**) Yes or No** If no, with whom do you live?_____________________________

Are you presently employed? (circle one) **Yes or No** If no why? __________________________________

Do you exercise regularly? (circle one) **Yes or No**

Do you need assistive devices to walk? (circle one) **Yes or No** If yes which one **walker cane wheelchair**

Do you smoke cigarettes now? (circle one**) Yes or No**

Do you use other tobacco products? (circle one) **Yes or No**

If yes, How many packs a day do you smoke?_____

How many years have you smoked? _____

If you quit, How many packs a day did you smoke? ____

How many years did you smoke for?____

Do you drink beer, wine, or liquor?____

If yes, how many do you drink per week?____

Do you use recreational drugs?_____

If yes, please explain:____

Medications

Name of Medication	Strength (example 800mg)	Dosage &Time	Reason for Medication