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◆◆2006 Data Sheet◆◆

Name: _____ DOB: _____ Date of Injury: _____

Language Spoken: _____ Describe your orthopedic problem today: _____

Lower Back Pain – if so, radiation to lower extremity Y N Neck Pain- if so, radiation to upper extremity Y N

Past History: Please circle any of the following that you been exposed to:

Hepatitis C Hepatitis A or B Active Hepatitis C Pneumonia HIV Aids MRSA
Other: _____

Do you have or have you ever had any of the following?

Anemia - Asthma - Blood Transfusion - Cancer – Diabetes - DVT (Deep Vein Thrombosis) – GI – Hypertension - Heart – Kidney – Liver – Lung - Pulmonary Embolus - Psychiatric problems (depression/psychosis) – Seizure - TIA (mini stroke)
Other: _____

Surgeries/Operations when: _____

Social History: Are you? R or L Handed Student - Child - Infant Children? Y N Ages?: _____

Occupation? _____ How long? _____

If not employed, date last worked? _____ Disability Y N

Do you drink alcohol? Yes No If yes, how much? _____ How long? _____ Beer Hard Liquor

Do you smoke? Yes No If yes, how much? _____ How long? _____

Do you use street drugs? Yes No If yes, list all: _____ Meth Cocaine Marijuana IVDA

Street drugs ever used? Yes No If yes, which ones? _____ Meth Cocaine Marijuana IVDA

Review of Symptoms: Do you have any of the following?

General/Constitutional: Body Aches – Chills – Fever

Musculoskeletal: Joint Pain - Muscle Pain

Neurological: Localized Weakness - Slurred Speech - Seizures

Current Medications: _____

Drug allergies: _____

If yes, what type of reaction: _____