

**BFOA 2012 DATA SHEET**

OFFICE USE ONLY: ACCT#: \_\_\_\_\_ DATE: \_\_\_\_\_ BY: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date of injury: \_\_\_\_\_

Language Spoken: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Describe your orthopedic problem today: \_\_\_\_\_

<b>Infection History</b>	no    yes	no    yes	no    yes
	<input type="radio"/> <input type="radio"/> Hepatitis	<input type="radio"/> <input type="radio"/> HIV/AIDS	<input type="radio"/> <input type="radio"/> MRSA
Other: _____			

<b>Chronic Illnesses</b>	no    yes	no    yes	no    yes
	<input type="radio"/> <input type="radio"/> Anemia	<input type="radio"/> <input type="radio"/> Diabetes	<input type="radio"/> <input type="radio"/> Hypertension/HPB
	<input type="radio"/> <input type="radio"/> Asthma / Bronchitis	<input type="radio"/> <input type="radio"/> DVT	<input type="radio"/> <input type="radio"/> Pacemaker / Defibr.
	<input type="radio"/> <input type="radio"/> Bleeding Disorders	<input type="radio"/> <input type="radio"/> Emphysema	<input type="radio"/> <input type="radio"/> Pulmonary Embolus
	<input type="radio"/> <input type="radio"/> Blood Clots	<input type="radio"/> <input type="radio"/> Reflux / Ulcer	<input type="radio"/> <input type="radio"/> Seizures
	<input type="radio"/> <input type="radio"/> Blood Transfusion	<input type="radio"/> <input type="radio"/> Heart Disease / MI	<input type="radio"/> <input type="radio"/> Sleep Apnea (CPAP)
	<input type="radio"/> <input type="radio"/> Cancer	<input type="radio"/> <input type="radio"/> Heart Arrhythmia	<input type="radio"/> <input type="radio"/> TIA (Stroke)
	<input type="radio"/> <input type="radio"/> Kidney / Liver	Other: _____	

<b>Review of Symptoms</b>	no    yes	no    yes	no    yes
	<input type="radio"/> <input type="radio"/> Blackouts	<input type="radio"/> <input type="radio"/> Unusual Headaches	<input type="radio"/> <input type="radio"/> Shortness of Breath
	<input type="radio"/> <input type="radio"/> Bone / Joint	<input type="radio"/> <input type="radio"/> Nausea / Diarrhea	<input type="radio"/> <input type="radio"/> Unusual Bleeding
	<input type="radio"/> <input type="radio"/> Chest Pain	<input type="radio"/> <input type="radio"/> Numbness / Tingling	
Other: _____			

<b>Alcohol Use</b>	<input type="checkbox"/> Denies _____ drinks per (choose one) <input type="radio"/> day <input type="radio"/> week <input type="radio"/> month <input type="radio"/> year
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<b>Smoking</b>	<input type="checkbox"/> Denies _____ packs per day for _____ year(s)
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<b>Employment</b>	<input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed <input type="checkbox"/> Work Related Injury <input type="checkbox"/> Employed
	<input type="checkbox"/> Unemployed <input type="checkbox"/> Disability <input type="checkbox"/> Retired    Occupation: _____

<b>Drug Use</b>	no    past    now	no    past    now
	<input type="radio"/> <input type="radio"/> <input type="radio"/> Meth	<input type="radio"/> <input type="radio"/> <input type="radio"/> Cocaine
	<input type="radio"/> <input type="radio"/> <input type="radio"/> Marijuana	<input type="radio"/> <input type="radio"/> <input type="radio"/> IV Drugs

<b>Surgeries</b>	<input type="checkbox"/> None _____
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<b>Anesthesia Complications</b>	no    yes	describe if yes
	Local: <input type="radio"/> <input type="radio"/>	_____
	General: <input type="radio"/> <input type="radio"/>	_____
	Family History: <input type="radio"/> <input type="radio"/>	_____

<b>Hospitalization</b> other than surgeries	<input type="checkbox"/> None _____
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**Preferred Pharmacy (name, city)** \_\_\_\_\_

CURRENT MEDICATIONS	name – dosage	CURRENT ALLERGIES	name – reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____