

# JAMES ROBERT LEBOLT, D.O.

Board Certified and Fellowship Trained in Sports Medicine & Orthopedic Surgery  
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"Team Physician Virginia Tech Hokies and Radford University Highlanders"

(Please Print) – Please fill out completely as much as possible

Name (First): \_\_\_\_\_ (M.I.) \_\_\_\_\_ (Last): \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Gender: \_\_\_\_\_ Right handed: \_\_\_\_\_ Left handed: \_\_\_\_\_ Ambidextrous: \_\_\_\_\_

Occupation: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Who is your Primary Doctor or Pediatrician? \_\_\_\_\_ Phone number: \_\_\_\_\_

## HISTORY OF PRESENT ILLNESS

Describe the condition that brought you to this office: \_\_\_\_\_

Is your injury: \_\_\_\_\_ Work Accident \_\_\_\_\_ Auto Accident \_\_\_\_\_ Slip and Fall \_\_\_\_\_ Sports Related \_\_\_\_\_ Other injury Related

Date when Accident/Injury occurred: \_\_\_\_\_ How long have symptoms been present: \_\_\_\_\_

Description of Accident/Injury: \_\_\_\_\_

Where did the Accident/Injury occur? \_\_\_\_\_

Contributing events or cause for symptoms: \_\_\_\_\_

Describe the severity and quality of pain: (sharp, dull, stabbing, etc.) \_\_\_\_\_

Circle rating of 1-10 for severity of symptoms with 10 being the greatest: 1 2 3 4 5 6 7 8 9 10

Frequency of symptoms: \_\_\_constant\_\_\_ intermittent\_\_\_ daily Duration of symptoms: \_\_\_constant\_\_\_ hours \_\_\_minutes\_\_\_ seconds

Do symptoms include? \_\_\_swelling\_\_\_ weakness\_\_\_ numbness\_\_\_ decreased motion\_\_\_ pins and needle sensation Other: \_\_\_\_\_

If applicable, is the joint? \_\_\_popping\_\_\_ locking\_\_\_ clicking\_\_\_ instability/giving way Other: \_\_\_\_\_

What activities worsen your condition? \_\_\_\_\_

When do the symptoms occur? \_\_\_morning\_\_\_ afternoon\_\_\_ evening\_\_\_ during exercise\_\_\_ after exercise

Have you been previously treated for this accident/injury elsewhere? \_\_\_\_\_ If yes, by whom? \_\_\_\_\_

Past treatment of your current problem: \_\_\_ice treatment\_\_\_ heat treatment\_\_\_ physical therapy\_\_\_ rest (length of time)\_\_\_ injections (how many?)\_\_\_\_\_

\_\_\_medications\_\_\_ related past surgeries for condition (specify procedure and date) \_\_\_\_\_

Do you have an attorney for this problem? \_\_\_ If yes: Attorney's Name: \_\_\_\_\_

Attorney's Address: \_\_\_\_\_

Attorney's Number: \_\_\_\_\_

If applicable, can we discuss this with your coach or trainer? \_\_\_\_\_ Coaches name: \_\_\_\_\_ Trainer's Name: \_\_\_\_\_

### \*\*\*\*\*WORK-RELATED INJURIES PLEASE COMPLETE THE FOLLOWING: \*\*\*\*\*

Are you still working? \_\_\_\_\_

Have you had a prior or similar work injury? \_\_\_\_\_

Can you do modified work at this time? \_\_\_\_\_ If yes, what type of work activities can you perform? \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PAST MEDICAL HISTORY – Check all that apply**

- |  |  |   |  |   |
|--|--|---|--|---|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Leukemia        | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Hiatal hernia        |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Drug Addiction  | <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Prostate enlargement |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Gout                | <input type="checkbox"/> HIV                  |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Liver disease        |
| <input type="checkbox"/> Other: _____        | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Psoriasis      | <input type="checkbox"/> Peptic Ulcer        |   |
| <input type="checkbox"/> Cancer (type) _____ |  |   |  |   |

**PAST SURGICAL HISTORY – Check all that apply**

- |   |   |  |  |  |
|---|---|--|--|--|
| <input type="checkbox"/> Appendectomy   | <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Heart Bypass            | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Skin Cancer Surgery |
| <input type="checkbox"/> Arthroscopy    | <input type="checkbox"/> Carpal Tunnel    | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Neck Surgery      | <input type="checkbox"/> Tonsillectomy       |
| <input type="checkbox"/> Back Surgery   | <input type="checkbox"/> C-Section        | <input type="checkbox"/> Hernia Repair           | <input type="checkbox"/> Pacemaker         | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Gall Bladder     | <input type="checkbox"/> Hysterectomy            | <input type="checkbox"/> Prostate Surgery  |  |

**ALLERGIES**

- |                                       |                                  |                                  |                                 |                                    |                               |
|---------------------------------------|----------------------------------|----------------------------------|---------------------------------|------------------------------------|-------------------------------|
| <input type="checkbox"/> Penicillin   | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine | <input type="checkbox"/> Novacaine | <input type="checkbox"/> Tape |
| <input type="checkbox"/> Other: _____ |                                  |                                  |                                 |                                    |                               |

**MEDICATIONS**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

**FAMILY HISTORY**

- |           |                                |                                   |            |   |
|-----------|--------------------------------|-----------------------------------|------------|---|
| Father :  | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased | Age: _____ | Medical Conditions or Cause of Death: _____ |
| Mother:   | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased | Age: _____ | Medical Conditions or Cause of Death: _____ |
| Brother : | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased | Age: _____ | Medical Conditions or Cause of Death: _____ |
| Sister :  | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased | Age: _____ | Medical Conditions or Cause of Death: _____ |
| Son:      | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased | Age: _____ | Medical Conditions or Cause of Death: _____ |
| Daughter: | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased | Age: _____ | Medical Conditions or Cause of Death: _____ |

**SOCIAL HISTORY**

- Marital Status:  Single  Engaged  Married  Divorced  Widow
- Alcohol Use:  None  Rare  Occasionally  Socially  Other: \_\_\_\_\_
- Smoking History:  Non-Smoker  Previous Smoker  Current smoker
- Packs per day? \_\_\_\_\_ How long? \_\_\_\_\_
- Packs per day? \_\_\_\_\_ How long? \_\_\_\_\_
- Sports:  Football  Baseball  Basketball  Soccer  Hockey  Rollerblading
- Karate  Skating  Golf  Tennis  Swimming  Cheerleading
- Running  Wrestling  Lacrosse  Dance  Jujitsu  Snow-skiing
- Snow-skiing
- Other: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**REVIEW OF SYSTEMS - (Please check all that apply)**

**Constitutional:**

- Weight gain
- Weight loss
- Fever
- Chills
- Fatigue

**Eyes:**

- Blurred vision
- Cataracts
- Need glasses for reading
- Contact lens
- Glaucoma
- Double vision

**Ears, Nose, Throat**

- Hearing loss
- Dry mouth
- Nasal congestion
- Sore Throat
- Tinnitus
- Dentures
- Dental work
- Jaw pain
- Loose teeth

**Cardiovascular**

- High blood pressure
- Chest pain
- Shortness of breath
- Dyspnea on exertion
- Angina
- Palpitations
- Intermittent Pain in lower legs or thighs
- Coolness of hands
- Blood Clots
- Swelling, edema
- Cyanosis

**Respiratory**

- Cough
- Difficulty breathing
- Wheezing
- Asthma treatment
- Emphysema
- Sputum production
- Blood in sputum

**Genitourinary**

- Burning on urination
- Blood in urine
- Difficulty voiding
- Urgency
- Frequency
- Flank pain
- Kidney stones
- History of UTI

**Gastrointestinal**

- Diarrhea
- Blood in stool
- Nausea
- Vomiting
- Ulcers
- Food intolerance

**Musculoskeletal**

- Joint pain
- Locking
- Swelling
- Giving way
- Partial giving way
- Loss of motion
- Pain with motion
  
- Decreased ability to walk
- Difficulty tying shoes
- Difficulty climbing stairs
- Difficulty sitting
- Difficulty standing
- Back pain
- Neck pain
- Shoulder pain
- Hip pain
- Knee pain
- Ankle pain
- Wrist pain
- Elbow pain
- Hand pain
- Joint stiffness
- Foot pain in morning
- Joint warmth
- History of Orthopedic Surgery

**Integumentary**

- Skin lesions
- Rash
- Redness of skin
- Moles
- Dry or Scaly skin
- Nail problems

**Neurological**

- Numbness
- Seizures
- Balance problems
- Tingling
- Dizziness
- Blackouts
- Migraines
- Headaches
- Difficulty walking
- Bowel or Bladder loss of control

**Psychiatric**

- Depression
- Anxiety
- Nervousness
- Insomnia
- History of psychiatric problems
- Addiction
- Drug use

**Endocrine**

- Hunger
- Thirst
- Frequent urination
- Hair loss
- Night sweats
- Weight loss
- Weight gain

**Hematological/Lymphatic**

- Bleeding problems
- Swelling
- History of Leukemia
- Anemia
- AIDS
- Cancer

Signature of person completing form \_\_\_\_\_ Date \_\_\_\_\_

Signature of provider reviewing form \_\_\_\_\_ Date \_\_\_\_\_