nevada orthopedics
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Medical History Screening Form

Today's Date:_____

Patient Name:_____ DOB:_____ Age:_____

Height:_____ Weight:_____

Marital Status: Married ☐ Divorced ☐ Separated ☐ Single ☐ Widow/Widower ☐

Work Status: Not working ☐ Currently working ☐ Disabled ☐ Retired ☐ Unemployed ☐

Occupation:_____ Employer:_____

Right Handed ☐ Left Handed ☐ Ambidextrous ☐

History Of Present Illness:

Reason for Visit:_____

Is this injury related to a: Car accident ☐ Date:_____ Work accident ☐ Date: _____

Any physical therapy?:_____ Did it help?:_____ How long did you go?:_____

Have you had any injections?:_____ How long did it help?:_____

What medication, over the counter or prescribed, have you used for this problem?:_____

Past/Family Medical History:

	You	Family
AIDS	☐	☐
Asthma	☐	☐
Atrial Fibrillation	☐	☐
Bladder Disease	☐	☐
Bleeding Disorder	☐	☐
Blood Clots (DVT)	☐	☐
Cancer	☐	☐
Chest Pain	☐	☐
Diabetes	☐	☐
Fibromyalgia	☐	☐
Gastrointestinal Disease	☐	☐
GERD	☐	☐
Glaucoma	☐	☐
Gout	☐	☐
HIV	☐	☐
Heart Disease	☐	☐
Heart Attacks/MI	☐	☐
Heart Murmur	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
High Cholesterol	☐	☐
Hodgkin's Disease	☐	☐
Hypertension	☐	☐
Hypothyroidism	☐	☐
Kidney Disease	☐	☐
Leukemia	☐	☐
Liver Disease	☐	☐
Lung Disease	☐	☐
Multiple Sclerosis	☐	☐
Osteoarthritis	☐	☐
Osteoporosis	☐	☐
Parkinson's Disease	☐	☐
Pneumonia	☐	☐
Prostate Disease	☐	☐
Rheumatoid Arthritis	☐	☐
Seizure Disorder	☐	☐
Stomach Ulcers	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Vascular Disease		

Other: _____

Allergies:

Any allergies to medication? Yes ☐ No ☐ Which medications:_____

Any allergies to metal? Yes ☐ No ☐ Which metals?_____

Any other allergies: _____

Do you have issues with anesthesia: _____

Patient Name: _____ DOB: _____ Age: _____

Medications: Please list all current medications name, dose, and frequency.

_____ _____

_____ _____

_____ _____

_____ _____

_____I GIVE NEVADA ORTHOPEDICS CONSENT TO ACCESS MY SURESCRIPTS HISTORY

Surgeries/Hospitalizations: Please list type of surgery or medical condition and year it was done.

_____ _____

_____ _____

_____ _____

_____ _____

Personal Habits:

Cigarettes: Yes ☐ Occasionally ☐ No ☐ **Pks/day**

Pipe/Cigar: Yes ☐ Occasionally ☐ No ☐

Illegal Drug Use: Yes ☐ Occasionally ☐ No ☐

If you answered yes, drug name: _____

Chew: Yes ☐ Occasionally ☐ No ☐

Alcohol: Yes ☐ Occasionally ☐ No ☐ **How much?**_____

Review of Systems: Please check any of the following that apply to you personally.

Eyes ☐
Eye disease or injury ☐
Wear glasses/contact lenses ☐
Blurred or double vision ☐

Ears/Nose/Mouth/Throat

Hearing loss or ringing ☐
Earaches or drainage ☐
Chronic sinus problems ☐
Nose bleeds ☐
Mouth sores ☐
Bleeding gums ☐
Bad breath or bad taste ☐
Swollen glands in neck ☐

Cardiovascular

History of pulmonary embolism ☐
Heart trouble ☐
Chest pain or palpitations ☐
Shortness of breath ☐
Severe cramping in legs ☐
Swelling of feet, ankles or hands ☐

Gastrointestinal

Loss of appetite ☐
Change in bowel movements ☐
Nausea or vomiting ☐
Frequent diarrhea ☐
Constipation ☐
Blood in stool ☐
Heartburn_ ☐
Peptic Ulcer ☐

Genitourinary

Frequent urination ☐
Burning or painful urination ☐
Blood in urine ☐
Incontinence ☐
Kidney stones ☐
Sexual difficulty ☐
Urinary tract infections ☐
Enlarged prostate ☐

Musculoskeletal

Joint pain, stiffness or swelling ☐
Shooting leg pain ☐
Weakness of muscles or joints ☐
Muscle pain or cramps ☐
Back pain ☐
Cold extremities ☐
Difficulties walking or standing ☐
Frequent dislocations ☐

Skin Conditions

Rash or itching ☐
Change in skin color ☐
Change in hair or nails ☐
Varicose veins ☐
Painful bumps in skin ☐

Neurological

Frequent headaches ☐
Nighttime cramps ☐
Convulsions, seizures or tremors ☐
Numbness, tingling or paralysis ☐

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Review of Systems (Continued):

Endocrine

- ☐ Glandular or hormone problem
- ☐ Excessive thirst or urination
- ☐ Heat or cold intolerance
- ☐ Excessive dry skin
- ☐ Excessive facial hair

General Health

- ☐ Good General Health Lately
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches
- ☐ Loss of appetite

- ☐ Respiratory Chronic cough
- ☐ Spitting up blood
- ☐ Asthma or wheezing
- ☐ Shortness of breath

Hematologic/Lymphatic

- ☐ Slow to heal cuts
- ☐ Bleeding or bruising tendency
- ☐ Anemia
- ☐ Phlebitis or blood clot
- ☐ Past transfusion
- ☐ Enlarged Glands

Patient Signature: _____ Date: _____

Medical History Reviewed By:

_____		_____
Medical Assistant Initals	**Date:**	**Physician Initals**