



Medical History and Screening Form

Patient Name:	Occupation:	Date
Referring Physician:	Family Doc:	Date of Birth:
Age:	<input type="checkbox"/> Left Handed <input type="checkbox"/> Right Handed	Height: Weight:

History of Present Illness

Reason for visit?	Have you ever been told you need a replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of injury: _____
How and When did the problem start?:	

Evaluation of Pain / Discomfort

What activities are you unable to do because of the pain?

Does the pain keep you awake at night? Details?
 Yes No

What makes it feel better?

What makes it feel worse?

Pain Scale (circle one number)	Mild			Moderate				Severe		
	No Pain	1	2	3	4	5	6	7	8	9

Previous Treatment for this problem

Which other Doctors have you seen for this problem?

What medications have you tried?

Any Physical Therapy?

Other treatments?

Is this being covered by Worker's Compensation? Yes No

Is there a lawsuit or litigation pending in regard to your injury? Yes No

Last date worked?

Current work restrictions?

Past Medical History (please check all that apply)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Gastrointestinal Disease	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Gout
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Prostate	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Thyroid (Hyper or Hypo)	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Cancer
<input type="checkbox"/> Parathyroid	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Vascular Disease (circulation)	<input type="checkbox"/> Other (describe)
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bladder Disease	_____
<input type="checkbox"/> Stroke	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Skin Disorder	_____
<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Bleeding Disorder	
<input type="checkbox"/> AIDS / HIV	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Current Pregnancy			

ANY current infections, open sores, or open wounds?

Patient Name: _____

Prior Surgeries (all prior surgery and approximate dates)

Prior Fractures (all prior fractures and approximate dates)

Family History

<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Malignant Hyperthermia	<input type="checkbox"/> Musculoskeletal Disease	<input type="checkbox"/> Other : _____
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Diabetes	_____

Social History

Married Single Divorced Widow/Widower Separated

Residence

Alone With Family With Friends Nursing Home Retirement Home Other:
Name of Assisted living facility: _____

User of:

Tobacco <input type="checkbox"/> Yes Pks/day _____ <input type="checkbox"/> No	Alcohol <input type="checkbox"/> Yes Frequency: _____ <input type="checkbox"/> No	Illicit / Illegal Drug use <input type="checkbox"/> Yes <input type="checkbox"/> No
---	--	--

Review of Symptoms (Please mark all that apply)

<u>Constitutional</u> <input type="checkbox"/> None <input type="checkbox"/> Weight loss or gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats	<u>Head / Eye / Ears / Nose / Throat</u> <input type="checkbox"/> None <input type="checkbox"/> Frequent or unusual headache <input type="checkbox"/> Hearing loss <input type="checkbox"/> Loss of vision <input type="checkbox"/> Mouth or Dental infections	<u>Gastrointestinal</u> <input type="checkbox"/> None <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea – Chronic <input type="checkbox"/> Bleeding problems
		<u>Skin / Integumentary</u> <input type="checkbox"/> None <input type="checkbox"/> Rashes <input type="checkbox"/> Birthmarks <input type="checkbox"/> Open wounds or sores <input type="checkbox"/> Drainage
<u>Musculoskeletal</u> <input type="checkbox"/> None <input type="checkbox"/> Multiple joint pain <input type="checkbox"/> Multiple joint swelling <input type="checkbox"/> Multiple joint stiffness <input type="checkbox"/> Generalized muscle weakness <input type="checkbox"/> Deformity	<u>Cardiovascular</u> <input type="checkbox"/> None <input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Blood clots in legs or lungs <input type="checkbox"/> Varicose veins	<u>Neurological</u> <input type="checkbox"/> None <input type="checkbox"/> Paralysis <input type="checkbox"/> Loss of sensation
		<u>Psychiatric</u> <input type="checkbox"/> None <input type="checkbox"/> Depression <input type="checkbox"/> Episodes of mania <input type="checkbox"/> Inability to sleep

I consent to treatment by Joint Replacement Center of Scottsdale. I grant permission to the physicians and employees to render routine medical care that includes, but is not limited to, diagnostic procedures and medical treatment, administration of approved drugs and nursing care, as well as other medical services provided as part of my medical treatment. I understand that no guarantee or assurance has been made as to the results that may be obtained.

Patient/Guardian Signature/Relationship

Date

History Reviewed By:

Nurse Signature

Date

Physician Signature

Date