American Health Network | bone & spine
The new standard in orthopaedic care

DATE:

AMERICAN HEALTH NETWORK
MEDICAL HISTORY SCREENING FORM
orthopaedics

NAME: ______________________________ FAMILY PHYSICIAN:______________________

DATE OF BIRTH:______________ AGE:________ OCCUPATION:______________________

HEIGHT:______________ WEIGHT:__________ HAND DOMINANCE: RIGHT OR LEFT

REASON FOR VISIT :____

PAIN SCALE (CIRCLE ONE): NO PAIN 1 2 (MILD) 3 4 5 6 7 (MODERATE) 8 9 10 (SEVERE)

NIGHT PAIN: YES NO

PHYSICAL THERAPY: YES NO; IF YES HOW LONG?_________ MEDICATION FOR PAIN:____________________

HAVE YOU HAD PREVIOUS SURGERY FOR THE PROBLEM? (DESCRIBE)______________________________

IS THIS A WORK RELATED INJURY? YES NO HAVE YOU FILED A WORKMANS COMP CLAIM? YES NO

PAST MAJOR MEDICAL HISTORY

- ☐ AIDS
- ☐ ANEMIA
- ☐ ASTHMA
- ☐ BLEEDING DISORDERS
- ☐ BLOOD CLOTS/DVT
- ☐ CANCER:____________
- ☐ DIABETES
- ☐ EMPHYSEMA
- ☐ FIBROMYALGIA
- ☐ GERD/REFLUX
- ☐ HIV
- ☐ GOUT
- ☐ HEART ATTACK WHEN:__________ __________
- ☐ HEART DISEASE
- ☐ HEPATITIS
- ☐ HYPERTENSION
- ☐ KIDNEY DISEASE
- ☐ OSTEOARTHRITIS
- ☐ RHEUMATOID ARTHRITIS
- ☐ SEIZURE DISORDER
- ☐ STROKES/TIA'S
- ☐ THYROID DISORDER
- ☐ ULCERS (STOMACH)
- ☐ OTHER MAJOR MEDICAL CONDITION: ______________ ______________ ______________ ______________ ______________

ALLERGIES

PAST MAJOR SURGICAL HISTORY

- ☐ ARTHROSCOPY: IF SO BY WHO, WHAT AND WHEN?__________________ __________________
- ☐ BACK OR NECK SURGERY (FUSIONS, ETC)
- ☐ JOINT REPLACEMENT: BY WHO, WHAT AND WHEN? __________________ __________________
- ☐ CABG (BYPASS): WHEN?__________
- ☐ GASTRIC BYPASS
- ☐ HYSTERECTOMY
- ☐ PACEMAKER
- ☐ STENTS
- ☐ NONE
- ☐ OTHER:______________ ______________ ______________

REVIEW OF SYSTEMS

- ☐ FEVER
- ☐ FATIGUE
- ☐ LOSS OF APPETITE
- ☐ CURRENT ILLNESS
- ☐ SLEEP APNEA
- ☐ SHORTNESS OF BREATH
- ☐ PNEUMONIA
- ☐ WHEEZING
- ☐ ARTHRITIS
- ☐ POOR BALANCE
- ☐ JOINT PAIN
- ☐ STIFFNESS
- ☐ NUMBNESS
- ☐ SWELLING
- ☐ DEFORMITIES
- ☐ ABDOMINAL PAIN
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ GERD
- ☐ ULCERS
- ☐ NAUSEA
- ☐ VOMITTING
- ☐ BLADDER INFECTION
- ☐ KIDNEY DISEASE
- ☐ RETENTION
- ☐ EASY BLEEDING
- ☐ EASY BRUISING
- ☐ CLOTTING DISORDER/BLOOD CLOTS
- ☐ STROKES
- ☐ TIA'S
- ☐ EPILEPSY
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ INSOMNIA
- ☐ MRSA HISTORY
- ☐ LATEX ALLERGY

SOCIAL HISTORY

OCCUPATION:______________________________

☐ CURRENTLY WORKING ☐ RETIRED ☐ DISABLED ☐ UNEMPLOYED

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

TOBACCO: Y N QUIT (WHEN)______________

☐ CHEW ☐ CIGARETTES;

PACKS/CANS PER DAY:____________________

HOW MANY YEARS?:____________________

ALCHOHOL: Y N
HOW MUCH?__________

ILLEGAL DRUG USE: Y N
IF YES, DRUG?__________________

PERTINENT FAMILY HISTORY

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Medication List

Patient Name:____

Date of Birth: ____/____/_____ **Today's Date:** ____/_____/______

Preferred Pharmacy:____

Pharmacy Telephone #____

Pharmacy Address: ____

Drug Name	Strength	How Taken	How Often
Example: Naprosyn	500mg	Orally	One time per day
Example: Advair	250/50	Inhaled	Two times per day