SPINE INSTITUTE OF NEVADA

Dr. Archie C. Perry
Board Certified Orthopedic Spine Surgeon

Located at DOC DESERT ORTHOPAEDIC CENTER

NAME: _____

MEDICAL HISTORY & REVIEW OF SYSTEMS

Please check all that apply ("Family" refers to parents, brothers, sisters or children)

Condition	You	Family
Cardiovascular		
Anemia	____	____
Blood clots	____	____
Heart attack	____	____
Heart murmur/palpitations	____	____
High blood pressure	____	____
Pacemaker	____	____
Pain/pressure in chest	____	____
Shortness of breath	____	____
Cancer	____	____
If "you" yes, Type _____		
If "Family" yes, Type _____		
Ears, Nose & Throat		
Deafness	____	____
Deviated septum	____	____
Earaches	____	____
Hay fever/Allergies	____	____
Loss of hearing	____	____
Nosebleeds	____	____
Sinus infections	____	____
Sinus problems	____	____
Wear dentures	____	____
Wear hearing aid	____	____
Endocrinologic		
Diabetes	____	____
Eyes		
Blindness	____	____
Cataracts	____	____
Dilated pupil	____	____
Eye injury	____	____
Glaucoma	____	____
Wear glasses	____	____
Gastrointestinal		
Abdominal bleeding	____	____
Colitis	____	____
Gallbladder disease	____	____
Hemorrhoids	____	____
Hiatal hernia	____	____
Indigestion	____	____
Intestinal bleeding	____	____
Jaundice	____	____
Loss of bowel control	____	____
Ulcer disease	____	____

Condition	You	Family
Genitourinary-Female Only		
Blood in urine	____	____
Kidney stone	____	____
Loss of bladder control	____	____
Menstrual problems	____	____
Sexual problems	____	____
Genitourinary-Male Only		
Bladder problems	____	____
Blood in urine	____	____
Kidney stone	____	____
Loss of bladder control	____	____
Sexual problems	____	____
Testicular pain	____	____
Hematologic/Lymphatic/Immunologic		
Anemia	____	____
Hepatitis	____	____
HIV / AIDS	____	____
Low blood sugar	____	____
Sickle cell	____	____
Thyroid problems	____	____
Musculoskeletal		
Fibromyalgia	____	____
Gout	____	____
Joint pain	____	____
Lupus	____	____
Muscle pain or cramps	____	____
Osteoarthritis	____	____
Rheumatoid arthritis	____	____
Stiffness/swelling joints	____	____
Trouble walking	____	____

Condition	You	Family
Neurological		
Alzheimers disease	____	____
Disorder of brain	____	____
Dizziness	____	____
Fainting spells	____	____
Headaches	____	____
Neuritis	____	____
Paralysis	____	____
Seizures / Epilepsy	____	____
Stroke	____	____
Side effected L / R		
Psychiatric		
Confusion/memory loss	____	____
Depression	____	____
Insomnia	____	____
Respiratory		
Asthma	____	____
Bronchitis	____	____
Chronic cough	____	____
Coughing up blood	____	____
Emphysema	____	____
Pain with breathing	____	____
Pneumonia	____	____
Shortness of breath	____	____
Sleep Apnea	____	____
Tuberculosis	____	____
Skin		
Psoriasis	____	____
Other _____	____	____

Women

	Yes	No
Are you pregnant now?	____	____
Date of last period	_____	
	Yes	No
Postmenopausal?	____	____
How many years?	_____	

Please explain any "yes" answers from above: _____

_____

_____

_____

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SPINE INSTITUTE OF NEVADA

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Board Certified Orthopedic Spine Surgeon

Welcome to the Spine Institute of Nevada located at the Desert Orthopaedic Center

Patient Information - Please Fill Out Completely

(Office use only) Patient Acct # _____

PATIENT INFORMATION Today's Date _____

Last Name _____ First _____ Middle _____

Address _____ City _____ St _____ Zip_____

Home Phone #(____) _____ Work #(____) _____Ext._____ Cell Phone #_____

Date of Birth _____ Age _____ Social Security # _____ Driver's License # _____ State _____

Marital Status: Married _____ Single _____ Widowed _____ Divorced _____ Separated _____ Sex M _____ F_____

E-mail address _____ Full Time Student: Yes ____ No ____ School Name: _____

Employer _____ Employer's Phone #_____ Usual Work Hours _____

Employer's Address _____ City _____ St _____ Zip_____

Name of Spouse (If applicable) _____ Date of Birth _____

Spouse's Employer _____ Employer's Phone #_____

Employer's Address _____ City _____ St _____ Zip _____

Nearest Relative/Friend (Not Living With You) _____ Phone # _____

GUARANTOR'S/PRIMARY POLICYHOLDER'S INFORMATION (IF DIFFERENT FROM PATIENT INFORMATION)

Last Name _____ First _____ Middle _____

Address _____ City _____ St _____ Zip_____

Home Phone #(____) _____ Work #(____) _____ Ext._____ Cell Phone #_____

Date of Birth _____ Age _____ Social Security # _____ Driver's License # _____ State _____

Marital Status: Married _____ Single _____ Widowed _____ Divorced _____ Separated _____ Sex M _____F _____

Employer _____ Employer's Phone #_____ Usual Work Hours _____

Employer's Address _____City _____ St _____ Zip_____

INSURANCE INFORMATION

Type of Insurance: Commercial Insurance _____ Medicare _____ Medicaid _____ Champus _____ Private Pay _____ Other _____

Worker's Comp _____ Worker's Comp Date of Injury _____

Primary Insurance Company Name _____ Phone # (_____) _____

Policyholder's Name _____ Soc. Sec.# _____ Date of Birth _____

Group # _____ ID #_____

Patient's Relationship to the Policyholder? Self _____ Spouse _____ Child _____

Secondary Insurance Company Name _____ Phone # (_____) _____

Policyholder's Name _____ Soc. Sec.# _____ Date of Birth _____

Group # _____ ID #_____

Employer _____ Employer's Phone # _____

Patient's Relationship to the Policyholder? Self _____ Spouse _____ Child _____

PAYMENT

I Will Be Paying Today By ☐ Check ☐ Cash ☐ Mastercard ☐ Visa ☐ Debit card