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: _____

_____

_____

_____

Continued on Next Page

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

Patient Injury / Referral - Please Fill Out Completely

Name of Referring Physician _____

Name of Primary Care Physician _____ Phone # (_____) _____ Fax (_____) _____

Physician's Address _____ City _____ St _____ Zip _____

Attorney (if applicable) _____ Phone # (_____) _____

Attorney's Address _____ City _____ St _____ Zip _____

INJURY / PROBLEM

Part of body being seen for _____ Left ____ Right ____ Have you seen a doctor for this problem? Yes ____ No ____

If yes, Doctors name _____ Date of visit _____

Are you being seen for an injury? Yes _____ No _____ If yes, Date of injury _____

How were you injured? Work(if yes, see below) _____ Auto(if yes, see below) _____ Other _____

If this is not related to an injury, when did problem begin? Date _____

Were X-rays or scans taken? Yes _____ No _____ If yes, where _____

If yes, did you bring X-rays or scans with you? Yes _____ No _____

WORK - RELATED INJURIES

Have you notified your employer? Yes _____ No _____

Employer at time of injury _____

Are you currently working? Yes _____ No _____ Date last worked _____

Have you completed an employer's C - 3 form? Yes _____ No _____

Have you completed a doctor's C - 4 form? Yes _____ No _____ Where? _____

Who is your Worker's Compensation (MCO) Carrier? _____

AUTO INJURIES

Have you notified your insurance company? Yes _____ No _____

Auto Insurance Company _____ Phone # (_____) _____

Auto Insurance Company Address _____ City _____ St _____ Zip _____

Date of accident _____ Claim # _____ Policy # _____

Adjuster Name _____

Do you have an Attorney involved with this case? Yes _____ No _____

Attorney's Name _____ Phone # (_____) _____

I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to the Spine Institute of Nevada, the Desert Orthopaedic Center and/or associated medical providers. I authorize the Spine Institute of Nevada and the Desert Orthopaedic Center to release any information, acquired in the course of my treatment, needed for this medical insurance claim. A photocopy of this authorization is to be considered as valid as the original until revoked by me in writing.

I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney or other third party payor is involved with payment. I am responsible for all co-payment and insurance co-insurance amounts, non-covered supplies and services, and yearly deductibles.

I understand that an appointment time does not guarantee that I will be seen at that time.

Payment for services is expected at the time services are rendered. If the Spine Institute of Nevada and the Desert Orthopaedic Center doctors, and associated medical providers, are Preferred Providers of your insurance carrier, we are required by your insurance company to collect your financial portion at the time services are rendered.

Signature _____ _____
Patient / parent / guardian Date