Theodore P. Firestone, M.D. FACS

Joint Replacement Center of Scottsdale

20401 North 73rd Street
Suite 160
Scottsdale, Arizona 85255
Phone: 480-237-5727
Fax: 480-657-3207

Medical History and Screening Form

Patient Name:	Occupation:	Date	
Referring Physician:	Family Doc:	Date of Birth:	
Age:	☐ Left Handed ☐ Right Handed	Height:	Weight:

History of Present Illness

Reason for visit?	Have you ever been told you need a replacement? ☐ Yes ☐ 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? ☐ Yes ☐ No Details?

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	10 Severe Pain

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)

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

☐ Bleeding Disorder
☐ Malignant Hyperthermia
☐ Osteoporosis
☐ Cancer
☐ Musculoskeletal Disease
☐ Diabetes
☐ Heart Disease
☐ Other : _____

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 ☐ Yes Pks/day _____ ☐ No
Alcohol ☐ Yes Frequency:_____ ☐ No
Illicit / Illegal Drug use ☐Yes ☐ No

Review of Symptoms (Please mark all that apply)

Constitutional
☐ None
☐ Weight loss or gain
☐ Fatigue
☐ Fever
☐ Chills
☐ Night Sweats

Head / Eye / Ears / Nose / Throat
☐ None
☐ Frequent or unusual headache
☐ Hearing loss
☐ Loss of vision
☐ Mouth or Dental infections

Gastrointestinal
☐ None
☐ Nausea
☐ Vomiting
☐ Diarrhea – Chronic
☐ Bleeding problems

Skin / Integumentary
☐ None
☐Rashes
☐ Birthmarks
☐ Open wounds or sores
☐ Drainage

Respiratory
☐ None
☐ Shortness of breath
☐ Difficulty breathing
☐ Productive cough

Genitourinary
☐ None
☐ Incontinence
☐ Frequency of urine
☐ Urgency of urine
☐ Retention of urine

Musculoskeletal
☐ None
☐ Multiple joint pain
☐ Multiple joint swelling
☐ Multiple joint stiffness
☐ Generalized muscle weakness
☐ Deformity

Cardiovascular
☐ None
☐ Chest pain or pressure
☐ Irregular heart beat
☐ Swelling of ankles
☐ Blood clots in legs or lungs
☐ Varicose veins

Neurological
☐ None
☐ Paralysis
☐ Loss of sensation

Psychiatric
☐ None
☐ Depression
☐ Episodes of mania
☐ 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

Patient Name: _____ Date: _____

Please list all current medications (including dietary supplements)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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_____ _____

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_____ _____

_____ _____

_____ _____

_____ _____

List any known drug allergies:

_____

_____

_____