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**Terry A. Clyburn M.D., P.A.**

MEDICAL HISTORY AND SCREENING FORM											
Patient Name:				Address Street:							
City:	State:	Zip:	Occupation:				Male <input type="checkbox"/> Female <input type="checkbox"/>				
How were you referred?				S.S. #		Date of Birth:					
Email address		<input type="checkbox"/> Left Handed <input type="checkbox"/> Right Handed		Height:		Weight:					
History of Present Illness											
Reason for visit?						Was this the result of a work or auto injury? <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? <input type="checkbox"/> Yes <input type="checkbox"/> 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
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 <input type="checkbox"/> Yes <input type="checkbox"/> No					If yes, Employer:						
Is there a lawsuit or litigation pending in regard to your injury? <input type="checkbox"/> Yes <input type="checkbox"/> No							D.O.I.				
Last date worked?					Current work restrictions?						
Past Medical History (please check all that apply)											
<input type="checkbox"/> Diabetes <input type="checkbox"/> Blood Clots <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Thyroid (Hyper or Hypo) <input type="checkbox"/> Parathyroid <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Stroke <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> AIDS / HIV <input type="checkbox"/> Current Pregnancy <input type="checkbox"/> Rheumatoid Arthritis		<input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Stomach Ulcers		<input type="checkbox"/> Gastrointestinal Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Prostate <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Vascular Disease (circulation) <input type="checkbox"/> Bladder Disease <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Skin Disorder		<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Gout <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer <input type="checkbox"/> Other (describe) _____ _____ _____ _____					
<b>ANY</b> current infections, open sores, or wounds?											

<b>Patient</b>		
<b>Prior Surgeries (all surgery and approximate dates)</b>		
<b>Prior Fractures (all fractures and approximate dates)</b>		
<b>Family History</b>		
<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	-----
<b>Social History</b>		
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Separated		
<b>Residence</b>		
<input type="checkbox"/> Alone <input type="checkbox"/> With Family <input type="checkbox"/> With Friends <input type="checkbox"/> Nursing Home <input type="checkbox"/> Retirement Home <input type="checkbox"/> Other		
Name of Assisted living facility: _____		
<b>User of:</b>		
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
<b>Review of Symptoms (please mark all that apply)</b>		
<b><u>Constitutional</u></b> <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	<b><u>Head / Eye / Ears / Nose / Throat</u></b> <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	<b><u>Gastrointestinal</u></b> <input type="checkbox"/> None <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea - Chronic <input type="checkbox"/> Bleeding problems
<b><u>Skin / Integumentary</u></b> <input type="checkbox"/> None <input type="checkbox"/> Rashes <input type="checkbox"/> Birthmarks <input type="checkbox"/> Open Wounds or sores <input type="checkbox"/> Dressings	<b><u>Respiratory</u></b> <input type="checkbox"/> None <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Productive cough	<b><u>Genitourinary</u></b> <input type="checkbox"/> None <input type="checkbox"/> Incontinence <input type="checkbox"/> Frequency of urine <input type="checkbox"/> Urgency of urine <input type="checkbox"/> Retention of urine
<b><u>Musculoskeletal</u></b> <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	<b><u>Cardiovascular</u></b> <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	<b><u>Neurological</u></b> <input type="checkbox"/> None <input type="checkbox"/> Paralysis <input type="checkbox"/> Loss of sensation  <b><u>Psychiatric</u></b> <input type="checkbox"/> None <input type="checkbox"/> Depression <input type="checkbox"/> Episodes of mania <input type="checkbox"/> Inability to sleep

Patient \_\_\_\_\_

**Medication Allergies:**  None or LIST \_\_\_\_\_

**Please List all Medications and Supplements** (please include dosage)  None

_____	_____
_____	_____
_____	_____
_____	_____

Insurance Information			
Primary Insurance Carrier:			
Subscriber I.D. #		Group No.	
If Spouse or Dependant, Policy holder name:		S.S. #	D.O.B.
Secondary Insurance Carrier:			
Subscriber I.D. #		Group No.	
If Spouse or Dependant, Policy holder name:		S.S. #	D.O.B.
Emergency Contact			
Name:		Telephone No.	
Address Street:		City:	
State:	Zip:	Relationship:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician and understand that I am financially responsible for any balance. I also authorize Dr. Clyburn or the insurance company to release my information required to process my claims.

Signed \_\_\_\_\_ Date \_\_\_\_\_