Southern Nevada Occupational Health Center

4100 N. MARTIN LUTHER KING BLVD., SUITE A
NORTH LAS VEGAS, NV 89032
PHONE: (702) 380-1712
FAX: (702) 380-1716

REGISTRATION SHEET

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY/STATE: _____

ZIP: _____ PHONE: _____ WORK PHONE: _____

CELL: _____ SS#: _____ GENDER: MALE / FEMALE

MARITAL STATUS: _____ RACE: _____ DRIVERS LICENSE: _____

NAME OF EMPLOYER: _____

JOB TITLE: _____ EMAIL ADRESS: _____

Thank you.

SOUTHERN NEVADA OCCUPATIONAL HEALTH CENTER
4100 N Martin Luther King Blvd., Ste. A
North Las Vegas, NV 89032
(702) 380-1712 OFFICE
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CONSENT TO TREATMENT AND CONDITIONS OF ADMISSION

GENERAL POLICY: All patients shall be treated, admitted and assigned accommodation without distinction to race, religion, color, national origin, age or handicapping conditions.

GENERAL DUTY NURSING: The hospital only provides general duty nursing care. Under this system, nurses are called to the bedside of the patient by a signal system. If the patient needs continuous special care, it is understood that the patient is responsible for the cost and the hospital is released from any and all liability arising from the fact that the said patient is not provided with such additional care.

My primary language is _____

Initial: _____ **PERSONAL VALUABLES:** This facility does not assume responsibility for lost or stolen items. The facility encourages that personal valuables be left at home or given to family or friends for safekeeping.

Initial: _____ **NON-SMOKING POLICY:** In accordance with regulatory agency standards, this facility is a non-smoking facility. I have received smoking cessation information. If I wish assistance on quitting smoking I may contact the Nevada Tobacco Users Helpline at (1-800-784-8669)

CAMERAS AND SURVEILLANCE EQUIPMENT: Patient has been advised the facility uses cameras and other surveillance equipment to monitor patient/employee activities. As a condition of admission, patient hereby consents to being monitored and recorded by such cameras and surveillance equipment.

EMERGENCY DEPARTMENT only/ PPO PHYSICIAN NOTIFICATION: It is the responsibility of the patients to inform the hospital of the primary care physician. If the hospital is unable to contact or utilize the services of your physician, a non-PPO physician may be assigned to you. This could result in an increase in cost to you, the patient.
My Primary Care Physician is: _____

Initial: _____ **USE OF THE EMERGENCY DEPARTMENT:** I understand that my insurance carrier/ 3rd party payor have the right to review my record for the use of emergency department. I understand that if the reason for my visit is determined by my insurance/ 3rd party payor to be a non-emergency, I will be responsible for the bill. I will be responsible for my triage bill, if after triage I decide to leave the Emergency Department without being evaluated by an ER physician.

HMO/PPO CLAIM REVIEW: If the patient is a member of a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), the insurance plan may not cover the physicians' or hospital's services or the benefits may be reduced if the physicians or hospital are not participating providers with insurance organizations. Many HMO/PPO Health Plans review emergency visit claims retrospectively. The health plans review board will determine whether the situation was an emergency. This could occur even if the undersigned's physician directed facility and physician charges. The facility is not responsible for determining whether the patient has used a participating provider for their insurance plan.

Initial: _____ I have received information on my Rights and Responsibilities as a patient and on the grievance process.

X_____
Signature of Patient/ Representative / Legal Guardian

Unable to sign: ☐ Serious Condition
☐ _____

Date: _____ Witness: _____ Hospital Representative: _____ Date: _____

Southern Nevada Occupational health Center

REVIEW OF SYSTEMS: PLEASE INDICATE ANY PERSONAL HISTORY BELOW

SYMPTOMS			MUSCULOSKELETAL		
Good general health	YES	NO	Joint pain	YES	NO
Recent weight change	YES	NO	Joint stiffness or swelling	YES	NO
Fever	YES	NO	Weakness of muscle or joints	YES	NO
Fatigue	YES	NO	Muscle pain or cramps	YES	NO
Headache	YES	NO	Back pain	YES	NO
			Cold extremities	YES	NO
EYES			Difficulty Walking	YES	NO
Eye disease or injury	YES	NO			
Wear glasses/contact lenses	YES	NO	**INTEGUMENTARY (skin, breast)**		
Blurred or double vision	YES	NO	Rash or itching	YES	NO
Glaucoma	YES	NO	Change in skin color	YES	NO
			Change in hair or nail	YES	NO
EAR/NOSE/MOUTH/THROAT			Varicose veins	YES	NO
Hearing loss or ringing	YES	NO	Breast pain	YES	NO
Earache or drainage	YES	NO	Breast lump	YES	NO
Chronic sinusitis problems or rhinitis	YES	NO	Breast discharge	YES	NO
Nosebleeds	YES	NO			
Mouth sores	YES	NO	**NEUROLOGICAL**		
Bleeding gums	YES	NO	Frequent or recurring headaches	YES	NO
Bad breath or bad taste	YES	NO	Lightheadedness or dizzy	YES	NO
			Convulsions or seizure	YES	NO
CARDIOVASCULAR			Numbness tingling sensation	YES	NO
Heart trouble	YES	NO	Tremors	YES	NO
Chest pain or angina pectoris	YES	NO	Paralysis	YES	NO
Palpitations	YES	NO	Stroke	YES	NO
Shortness of breath walking or lying flat	YES	NO	Head injury	YES	NO
Swelling of feet, ankle, or hand	YES	NO			
			PSYCHIATRIC		
RESPIRATORY			Memory loss or confusion	YES	NO
Chronic or frequent chough	YES	NO	Nervousness	YES	NO
Spitting up blood	YES	NO	Depression	YES	NO
Shortness of breath	YES	NO	Insomnia	YES	NO
Asthma or wheezing	YES	NO			
			ENDOCRINE		
GASTROINTESTINAL			Glandular or hormone problems	YES	NO
Loss of appetite	YES	NO	Thyroid disease	YES	NO
Change in bowel movement	YES	NO	Diabetes (insulin & non-insulin)	YES	NO
Nausea or vomiting	YES	NO	Excessive thirst or urination	YES	NO
Painful bowel movement	YES	NO	Heat or cold interference	YES	NO
Constipation	YES	NO	Skin becoming dryer	YES	NO
Rectal bleeding or blood in stool	YES	NO	Change in hat, glove size	YES	NO
Abdominal pain	YES	NO			
Peptic ulcer	YES	NO	**HEMATOLOGIC/LYMPHATIC**		
Stomach or duodenal	YES	NO	Slow to heal cuts	YES	NO
			Bleeding or bruising tendency	YES	NO
GENTOURINARY			Anemia	YES	NO
Frequent urination	YES	NO	Phlebitis	YES	NO
Burning or painful urination	YES	NO	Enlarged glands	YES	NO
Blood in urine	YES	NO			
Change in force of stream when urinating	YES	NO	**ALLERGIC/IMMUNOLOGIC**		
Incontinence or dribbling	YES	NO	History of skin reaction or other adverse reaction to:		
Kidney stones	YES	NO	Penicillin or other antibiotics	YES	NO
Sexual difficulty	YES	NO	Morphine, Demerol or other narcotics	YES	NO
Male- testicular pain	YES	NO	Novocain or other anesthetics	YES	NO
Female- pain with period	YES	NO	Aspirin or other pain medicines	YES	NO
Female- irregular periods	YES	NO	Tetanus antitoxin or other serums	YES	NO
Female- vaginal discharge	YES	NO	**WT:** **HT:**		
Female- number of pregnancies			**BP:** **TEMP:** **HR:**		
			RR: **SpO2:** **Pain Scale:**		
No Change from prior visit	YES	NO	**Comments:**		

Patient Name (print): _____ **Date:** _____

Amir Nicknam, M.D.
Southern Nevada Occupational Health Center
4100 Martin Luther King Blvd. Suite A
North Las Vegas, NV 89032

Name:

HISTORY AND PHYSICAL EXAMINATION HISTORIA MEDICA Y EXAMEN FISICO

PERSONAL DATA DATOS PERSONALES

7876-05 (9/04)

I. MEDICAL: Have you ever had or have now any of the following illnesses (Check Yes/No)

I. Ha tenido o tiene alguna de estas enfermedades (Marque Si/No)

YES SI	NO	
☐	☐	Allergies ...Alergias
☐	☐	Anemia .. Anemia
☐	☐	Anxiety/Nervousness Psychiatric Illness ..Ansiedad/nerviosismo Trastornos psyquiátricos
☐	☐	Athritis/Rheumatism ...Artritis/Reumatismo
☐	☐	Asthma ... Asthma
☐	☐	BCG Vaccination .Vacuna BCG
☐	☐	Back/Neck Problems ...Problemas de espalda/cuello
☐	☐	Bladder Irritations ...Irritacion de vejiga
☐	☐	Bowel problems ...Problemas con intestinos
☐	☐	Bursitis .. Bursitis
☐	☐	Cancer ...Cancer
☐	☐	Carpal Tunnel Syndrome ...Sindrome del tunel del carpo

YES SI	NO	
☐	☐	Chest Pain/Pressure .. Dolor/presion de el pecho
☐	☐	Chicken Pox ..Viruela Loca
☐	☐	Chronic Cough ...Tos cronica
☐	☐	Cold/heat Intolerance ...Intolerancia a frio/calor
☐	☐	Dermatitis ....Inflamacion de la piel
☐	☐	Diabetes ...Diabetis
☐	☐	Dizziness/Fainting ...Mareos/desmayos
☐	☐	Emphysema ..Enfisema
☐	☐	Epilepsy/Seizures ...Epilepsia/ataques
☐	☐	Frequent Headache ...Dolores de cabeza
☐	☐	Fequent Sore Throat ...Dolores de garganta
☐	☐	Gallbladder Problems ...Problemas de vesicula
☐	☐	Glaucoma/Cataracts ...Glaucoma/cataratas

YES SI	NO	
☐	☐	Heart Attack ...Ataque al corazon
☐	☐	Hearing Problems ...Problemas de oir
☐	☐	Hemmorhoids/Piles ...Hemorrhoides/almorranas
☐	☐	Hernia/Ruptures ...Hernia/rupturas
☐	☐	High/Low Blood Pressure ....Presion alta/baja
☐	☐	Jaundice/Yellow Skin ...Palidez/piel amarilla
☐	☐	Kidney Problems ...Problemas del rinon
☐	☐	Liver Disease ...Enfermedad del higado
☐	☐	Loss of Consciousness ...Pérdida de conocimiento
☐	☐	Malaria ...Malaria
☐	☐	Measles ...Sarampion
☐	☐	Paralysis/Weakness ...Parálisis/debilidad
☐	☐	Perforated Ear Drum ...Timpano perforado

YES SI	NO	
☐	☐	Pneumonia . Pulmonia
☐	☐	Reactions to Chemicals ...Reaccion de su invalidéz
☐	☐	Rheumatic Fever ...Fiebre reumatica
☐	☐	Shortness of breath .. Respiracion corta
☐	☐	Skin Disorders/Rashes ....Desorden de piel/Eritema
☐	☐	Sleeping Problems ..Problemas al dormir
☐	☐	Stomach Ulcers ...Ulceras del éstomago
☐	☐	Stroke (CVA) .,Ataque cardiovascular
☐	☐	Syphillis/Gonorrhea ...Sifilis/gonorrea
☐	☐	Thyroid Problems ...Problemas tiroides
☐	☐	Tuberculosis (T.B.) ..Tuberculosis
☐	☐	Varicose Veins ...Venas varicosas
☐	☐	Weight Loss/Gain ...Aumento/perdida de peso

DO YOU SMOKE USTED FUMA ☐ YES SI ☐ NO NO

IF SO, HOW MUCH PER DAY SI FUMA, CUANTO POR DIA

DO YOU DRINK ALCOHOLIC BEVERAGES TOMA BEBIDAS ALCOHOLICAS ☐ YES SI ☐ NO NO

IF SO, HOW OFTEN SI TOMA, CON CUANTA FREQUENCIA ☐ OCCASIONAL OCASIONALMENTE ☐ MODERATE MODERADAMENTE ☐ FREQUENT FEQUENTEMENTE

HAVE YOU EVER HAD SURGERY ALGUNA VEZ HA TENIDO CIRUJIA ☐ YES SI ☐ NO NO

HAVE YOU EVER BEEN ADVISED TO HAVE SURGERY ALGUNA VEZ LE HAN ACONSEJADO QUE TENGA CIRUJIA

ARE YOU ALLERGIC TO ANY DRUGS TIENE ALERGIA A ALGUNA MEDICINA ☐ YES SI ☐ NO NO

IF SO, LIST SI ES ASI, LISTE CUAL

ARE YOU TAKING ANY MEDICATIONS PRESENTLY ESTA TOMANDO ALGUNA MEDICINA AHORA ☐ YES SI ☐ NO NO

IF SO, LIST SI ES ASI, LISTE CUAL

FOR WOMEN: HAVE YOU EVER HAD MENSTRUAL PROBLEMS PARA DAMAS: ALGUNA VEZ HA TENIDO PROBLEMAS MENSTURALES ☐ YES SI ☐ NO NO

ARE YOU CURENTLY PREGNANT? ☐ YES ☐ NO

DATE OF LAST MENSTRUAL PERIOD _____ FECHA DE SU ULTIMO CICLO MENSTRUAL _____

C. FAMILY HISTORY: Have your parents, grandparents, sisters, or brothers had:

C. HISTORIA DE FAMILIA: Sus padres, abuelos, hermanas o hermanos han tenido:

YES SI	NO		RELATIONSHIP RELACION
☐	☐	T.B./Lung Disease ...Tuberculosis/enfermedad de pulmones	
☐	☐	Diabetes ..Diabetis	
☐	☐	High/Low Blood Pressure ...Presion alta o baja	
☐	☐	Mental Illness ...Enfermedad mental	
☐	☐	Heart Trouble ...Problemas con el corazon	
☐	☐	Cancer ..Cancer	

D. INJURIES: Have you ever had:

D. INJURIES: Ha tenido alguna vez:

☐	Fractures ...Fracturas
☐	Back Injuries ...Problemas de espalda
☐	Knee Injuries ...Problemas de rodilla
☐	Head Injuries ...Problemas de cabeza
☐	Lost Consciousness ...Perdida de conciencia