Duke Amputee Clinic at Patterson Place

Patient Registration Form

FOR US TO PROCESS YOUR CHART, PLEASE COMPLETE FULLY AND PRINT CLEARLY

PATIENT INFORMATION

NAME: _____ TODAY'S DATE: _____

BIRTHDATE: _____ AGE: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

_____ OCCUPATION: _____

CITY STATE ZIP

EMPLOYER: _____

PHONE #: _____ WORK PHONE #: _____

CELL PHONE #: _____ E-MAIL ADDRESS: _____

INSURANCE PRIMARY: _____

SPOUSE/PARENT: _____ SUBSCRIBER: _____

SECONDARY: _____

SUBSCRIBER: _____

OTHER INSURANCE: _____

SUBSCRIBER: _____

PRIMARY CARE DOCTOR: _____

☐ **I don't have one**

ADDRESS: _____

_____

CITY STATE ZIP

PHONE #: _____

REFERRING HEALTHCARE PROFESSIONAL: _____

(MD, PT, Chiropractor, etc.)

☐ **No one referred me**

ADDRESS: _____

_____

CITY STATE ZIP

PHONE #: _____

PREFERRED PHARMACY: _____

☐ **I don't have a pharmacy preference**

ADDRESS: _____

_____

CITY STATE ZIP

PHONE #: _____ FAX #: _____

HPI

Check reason for coming to clinic today:
____ First post-operative appointment
____ Requesting education, services or consultation
____ Other _____

Check all that apply:
____ Live alone
____ Live with family
____ Live with spouse
____ Live with child
____ Live with friend
____ Live in rehab facility
____ Live in skilled nursing facility
____ Live in home
____ Live in apartment
____ Other _____

Please check all current equipment:
____ Manual wheelchair
____ Electric wheelchair or scooter
____ Crutches
____ Walker
____ Other _____
____ Cane
____ Bedside commode
____ Shower bench
____ Prostheses (specify) _____

Please check all rehab services you have had to date:
____ Inpatient PT/OT
____ Inpatient rehab
____ Home health PT/OT
____ Outpatient PT/OT
____ Home health wound care

PAST MEDICAL HISTORY

□ Right Handed □ Left Handed □ Ambidextrous

□ AIDS/HIV	□ Cancer-Breast	□ Diabetes	□ Hepatitis	□ Sleep apnea
□ Alcoholism	□ Cancer-Colon	□ Drug Abuse	□ Kidney Disease	□ Pacemaker
□ Alzheimer's	□ Cancer-Lung	□ GERD	□ Osteoarthritis	□ High blood pressure
□ Anemia	□ Cancer-Prostate	□ Gout	□ Rheumatoid Arthritis	□ Chest Pain
□ Asthma	□ COPD	□ Heart Disease	□ Seizures	□ Sickle Cell Anemia
□ Blood Clots	□ Depression	□ Hypertension	□ Ulcers	□ Stroke

□ OTHER: (Thyroid, Heart attack, reflux, use of blood thinners) _____
_____

FEMALE PATIENTS ONLY: Are you pregnant, or is there a chance you may be pregnant? _____
First day of last menstrual period _____

SURGICAL HISTORY

□ Orthopaedic Surgeries _____
□ Tonsillectomy, when? _____
□ Appendectomy, when? _____
□ Gall Bladder Removed, when? _____
□ Hysterectomy, when? _____
□ Other _____
_____
_____

CURRENT MEDICATIONS □ None

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DRUG ALLERGIES □ None

_____	_____	_____
_____	_____	_____

FAMILY MEDICAL HISTORY (Mother, Father, Siblings, Grandparents)

Disease	Relationship to patient	Disease	Relationship to patient
□ AIDS/HIV	_____	□ Gout	_____
□ Alcoholism	_____	□ Heart Disease	_____
□ Alzheimer's	_____	□ Hypertension	_____
□ Anemia	_____	□ Kidney Disease	_____
□ Arthritis	_____	□ Osteoporosis	_____
□ Asthma	_____	□ Stroke	_____
□ Cancer	_____	□ Heart Attack	_____
Where? _____		□ Other _____	_____
□ Depression	_____	_____	_____
□ Diabetes	_____	_____	_____
□ Drug Abuse	_____	_____	_____

SOCIAL HISTORY

Current Job: _____ **Employer**: _____

Marital Status: Single Married Domestic Partner Divorced Separated Widowed

Children: Sons _____ Daughters: _____
How many? How many?

Tobacco: Circle one: Yes No Quit
Type: _____
(Cigarettes, Cigars, Chewing, Pipe)
Packs/day _____
Years smoked _____
Year quit _____

Alcohol: Circle one: Yes No Quit
Amount _____
Frequency _____
Year quit _____

Illicit Drugs: Circle one Yes No Quit
Type _____
Years used _____
Year quit _____

Review of Systems

Constitutional
- ☐ Weight gain
- ☐ Weight Loss
- ☐ Fever
- ☐ Weakness
- ☐ Malaise
- ☐ Insomnia
- ☐ Fatigue
- ☐ Chills
- ☐ Night sweats

Respiratory
- ☐ Short of breath
- ☐ Cough
- ☐ Breathing pain
- ☐ Wheezing
- ☐ TB Exposure

Gastrointestinal
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting ☐ Blood
- ☐ Diarrhea
- ☐ Constipation
- ☐ Dark stool ☐ Blood
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Jaundice

Dermatological
- ☐ Contact allergy
- ☐ Rashes

Metabolic
- ☐ Cold intolerant
- ☐ Heat Intolerant

Immunological
- ☐ Asthma
- ☐ Contact dermatitis
  Type? _____
- ☐ Bee sting allergy
- ☐ Food allergies
  Type of food? _____

HEENT
- ☐ Headaches
- ☐ Double vision
- ☐ Blurred vision
- ☐ Hearing Loss
- ☐ Ringing in ears
- ☐ Vertigo/World spinning
- ☐ Difficulty swallowing

Cardiovascular
- ☐ Chest pain
- ☐ Feel heart beating hard
- ☐ Fainting spells

Genitourinary
- ☐ Frequency
- ☐ Urgency
- ☐ Blood in urine
- ☐ Frequent night-time urination
- ☐ Incontinence

Neurological
- ☐ Seizures
- ☐ Tremors
- ☐ Numbness/Tingling
- ☐ Dizziness/Lightheaded
- ☐ Loss of coordination
- ☐ Difficulty walking
- ☐ Memory loss
- ☐ Depression

Hematologic
- ☐ Easy bruising
- ☐ Easy bleeding

Reproductive
- ☐ Pain interfering with sex

Other
- ☐ _____
  _____