North Carolina Orthopaedic Clinic

Patient Registration Form

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

PATIENT INFORMATION:

NAME: _____ TODAY'S DATE: _____

BIRTHDATE: _____ AGE: _____ HOME PHONE #: _____

ADDRESS: _____ CELL PHONE #: _____

_____ _____ EMAIL: _____

CITY STATE ZIP

EMPLOYMENT INFORMATION:

OCCUPATION: _____ EMPLOYER: _____

WORK PHONE #: _____

PAYOR INFORMATION:

INSURANCE PRIMARY: _____ SUBSCRIBER: _____
SECONDARY: _____ SUBSCRIBER: _____
OTHER INSURANCE: _____ SUBSCRIBER: _____

SOCIAL INFORMATION:

RACE (Circle One): **White** **Black** **Alaskan-Native** **American-Indian** **Asian** **Hawaii-Pacific**

Multi-Racial **Unavailable** **Declined** **All Other**_____

ETHNICITY (Circle One): **Hispanic or Latino** **Unavailable** **Declined** **Other**_____

LANGUAGE (Circle One): **English** **Spanish** **Chinese** **Other**_____

MARITAL STATUS (Circle One): **Single** **Married** **Domestic Partner** **Divorced** **Separated** **Widowed**

CHILDREN: SONS? **(Yes) (No)** DAUGHTERS? **(Yes) (No)**
How Many_____ How Many_____

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 one**

ADDRESS: _____

_____

CITY STATE ZIP

PHONE #: _____ FAX #: _____

NOTICE AND RELEASE OF MEDICATION HISTORY:

I give permission for my physician to access my medication history from the National Surescripts Database.

Sign _____ Date _____

DRUG ALLERGIES ☐ None

Allergy:_____ Allergy:_____ Allergy:_____ Allergy:_____
Reaction: _____ Reaction_____ Reaction:_____ Reaction:_____

CURRENT MEDICATIONS ☐ None

_____ _____ _____
_____ _____ _____
_____ _____ _____

PAST MEDICAL HISTORY: (Circle All that Apply) ☐ All Negative

Alcohol abuse	+	GERD	+	Osteoarthritis	+
Anemia	+	Gout	+	Prostate cancer	+
Asthma	+	Heart disease	+	Rheumatoid arthritis	+
Breast cancer	+	Hepatitis	+	Seizures	+
Colon cancer	+	HIV/AIDS	+	Sickle cell anemia	+
COPD	+	Kidney disease	+	Sleep apnea	+
Depression	+	Lung cancer	+	Stroke	+
Diabetes mellitus	+	Lupus	+	Ulcers	+
OTHER:	+				

FEMALE PATIENTS ONLY: Are you pregnant, or is there a chance you may be pregnant? **(Yes) (No)**
First day of last menstrual period _____

PAST SURGICAL HISTORY: (Circle All that Apply) ☐ All Negative

		Date:	Laterality:			Date:	Laterality:
Appendectomy	+		(L) (R)	Hysterectomy	+		(L) (R)
Back surgery	+		(L) (R)	Joint replacement	+		(L) (R)
Cholecystectomy	+		(L) (R)	Knee arthroscopy	+		(L) (R)
Coronary angioplasty	+		(L) (R)	Mastectomy	+		(L) (R)
C-Section	+		(L) (R)	Pacemaker	+		(L) (R)
Fracture surgery	+		(L) (R)	Tonsillectomy	+		(L) (R)
Hernia repair	+		(L) (R)	Tubal ligation	+		(L) (R)
Hernia repair	+		(L) (R)	Vasectomy	+		(L) (R)

FAMILY MEDICAL HISTORY: (Circle All that Apply) ☐ All Negative

Condition		Relationship to Patient (ie. mother, sister, son, grandparent on mother's side)
Alcohol abuse	+	
Anemia	+	
Asthma	+	
Breast cancer	+	
Colon cancer	+	
COPD	+	
Depression	+	
Gout	+	
Heart disease	+	
Hepatitis	+	
HIV	+	
Kidney disease	+	

Family Medical History CONTINUED… ☐All Negative

Condition		Relationship to Patient (ie. mother, sister, son, grandparent on mother's side)
Lung cancer	+	
Lupus	+	
Osteoarthritis	+	
Prostate cancer	+	
Reflux disease	+	
Rheumatoid arthritis	+	
Seizures	+	
Sickle cell anemia	+	
Sleep Apnea	+	
Stroke	+	
Ulcers	+	
OTHER:	+	

SOCIAL HISTORY

Alcohol Use (Circle One): **(Yes) (No)**
Drinks/Week: _____ **Glasses of Wine**
_____ **Cans of Beer**
_____ **Shots of Liquor**
_____ **Drinks containing 0.5 oz of alcohol**

Drug Use:
(Circle One)**: (Yes) (No)**
Frequency Per Week: _____ **Comments:**_____
Type(s): _____

Tobacco Use:
(Circle One)**: (Current Everyday) (Current Someday) (Former) (Never)**
Packs/day (Circle One)**: 0.25 0.5 1.0 1.5 2.0 3 Other:**_____
Quit Date:_____

Smokeless Tobacco (Circle One): **(Current User) (Former User) (Never)**
Quit Date:_____

FALLS ASSESSMENT: Do you need assistance with ambulation (walking)? **(Yes) (No)**
Do you have a history of falling within the last 90 days? **(Yes) (No)**

REVIEW OF SYSTEMS: (Circle All that Apply OR Check All Negative Under Each Section)

Constitutional ☐All Negative

+	Activity Change	+	Crying	+	Fever
+	Appetite Change	+	Diaphoresis (excessive sweating)	+	Irritability
+	Chills	+	Fatigue	+	Unexpected Wt. Gain

HEENT ☐All Negative

+	Facial Swelling	+	Ear Pain	+	Sneezing	+	Trouble Swallowing
+	Neck Pain	+	Tinnitus (ringing in ears)	+	Dental problem	+	Voice Change
+	Neck Stiffness	+	Nosebleeds	+	Drooling		
+	Ear Discharge	+	Congestion	+	Mouth Sores		
+	Hearing Loss	+	Rhinorrhea (runny nose)	+	Sore Throat		

Eyes ☐All Negative

+	Eye Discharge	+	Eye Redness
+	Eye itching	+	Photophobia (light sensitivity)
+	Eye Pain	+	Visual Disturbance

Respiratory ☐All Negative

+	Apnea	+	Stridor
+	Choking	+	Wheezing
+	Cough		

Cardiovascular ☐All Negative

+	Chest Pain
+	Cyanosis
+	Leg Swelling
+	Palpitations

Gastrointestinal ☐All Negative

+	Abdominal distention	+	Diarrhea
+	Abdominal Pain	+	Nausea
+	Anal bleeding	+	Rectal Pain
+	Blood in stool	+	Vomiting
+	Constipation		

Endocrine ☐All Negative

+	Cold Intolerance
+	Heat Intolerance
+	Polydipsia (excessive thirst)
+	Polyphagia (increased appetite)
+	Polyuria (excessive urination)

Genitourinary ☐All Negative

+	Difficulty urinating	+	Genital sore	+	Scrotal swelling
+	Dysuria	+	Hematuria	+	Testicular pain
+	Enuresis (incontinence)	+	Penile discharge	+	Urgency
+	Flank pain	+	Penile pain	+	Urine decreased
+	Frequency	+	Penile swelling		

Muscular ☐All Negative

+	Arthralgia (joint pain)
+	Back Pain
+	Gait problem
+	Joint Swelling
+	Myalgia (muscle pain)

Allergy/Immuno ☐All Negative

+	Environmental allergies
+	Food Allergies
+	Immunocompromised

Neurological ☐All Negative

+	Facial asymmetry	+	Syncope (fainting)
+	Headaches	+	Tremors
+	Seizures	+	Weakness
+	Speech difficulty		

Hematologic ☐All Negative

+	Adenopathy (enlarged lymph nodes)
+	Bruises/bleeds easily

Behavioral ☐All Negative

+	Agitation	+	Hallucinations	+	Self-injury
+	Behavioral problem	+	Hyperactive	+	Sleep disturbance
+	Confusion				

Skin ☐All Negative

+	Color change
+	Pallor (pale/sickly color)
+	Rash
+	Wound

Other:

+	

HEIGHT:_____ WEIGHT:_____ PAIN SCORE: 0 1 2 3 4 5 6 7 8 9 10

What is your complaint?_____ BODY PART: RIGHT, LEFT, or BOTH KNEE HIP

HAVE YOU HAD PREVIOUS SURGERY ON YOUR HIPS or KNEES? YES NO If yes, please specify:

Right/ Left	SURGERY	DATE	PHYSICIAN	HOSPITAL	CITY/STATE

WHEN JOINT IS PAINFUL, IS IT:

Choose one:

- ☐ Sharp
- ☐ Dull
- ☐ Burning
- ☐ Achy

Choose one:

- ☐ Slight, Occasional (no compromise on activities)
- ☐ Mild (makes no effect on normal daily activities)
- ☐ Moderate (active but make modifications to activities)
- ☐ Severe (major pain with significant limitations)
- ☐ Totally Disabled (crippled, bedridden)

HOW LONG HAS THIS BOTHERED YOU: (Please check one)

#_____ Days #_____weeks #_____months #_____years

SYMPTOMS BEGAN:

- ☐ With normal activities
- ☐ With higher level of activity than normal daily routine
- ☐ With sports (which sport? _____)
- ☐ Minor trauma (type of injury_____ when?_____)
- ☐ Severe trauma (type of injury_____ when?_____)

CURRENTLY SYMPTOMS BOTHER YOU WHEN: (Check all that apply)

- ☐ Constantly
- ☐ With normal daily activities
- ☐ In bed (keeps you awake)
- ☐ At rest ONLY
- ☐ Bending/squatting
- ☐ Using stairs
- ☐ Rising from a chair
- ☐ With sports
- ☐ During higher levels of activity
- ☐ Unpredictable, without relation to activity

PAIN LOCATION:

- ☐ Generalized
- ☐ Medial (inside) knee
- ☐ Lateral (outside) knee
- ☐ Anterior (front) knee
- ☐ Posterior (back) knee
- ☐ Anterior/Groin (front) hip
- ☐ Lateral/Trochanter (outside) hip
- ☐ Posterior/Buttock (back) hip
- ☐ Medial (inside) hip

MEDICATIONS YOU HAVE TRIED IN THE PAST:

- ☐ No medications
- ☐ Tylenol (acetaminophen)
- ☐ NSAIDS (ibuprofen, aleve, Celebrex, Mobic, etc)
- ☐ Narcotics (which ones?_____)
- ☐ Oral steroids
- ☐ Cortisone injections
- ☐ Hyaluronic acid (synvisc) injections
- ☐ Fish oil
- ☐ Glucosamine
- ☐ Muscle relaxants

MEDICATIONS YOU CURRENTLY TAKE:

- ☐ No medications
- ☐ Tylenol (acetaminophen)
- ☐ NSAIDS (ibuprofen, aleve, Celebrex, Mobic, etc)
- ☐ Narcotics (which ones?_____)
- ☐ Oral steroids
- ☐ Cortisone injections
- ☐ Hyaluronic acid (synvisc) injections
- ☐ Fish oil
- ☐ Glucosamine
- ☐ Muscle relaxants

OTHER THINGS TRIED FOR PAIN/SYMPTOM RELIEF:

- ☐ No modalities
- ☐ Brace/splint
- ☐ Elevation
- ☐ Gait Aids (cane, crutches, walker)
- ☐ Heat
- ☐ Ice
- ☐ Rest
- ☐ Physical therapy
- ☐ Massage

PAIN IS RELIEVED BY:

- ☐ Nothing adequately works
- ☐ Medications as above
- ☐ Brace/splint
- ☐ Elevation
- ☐ Exercise
- ☐ Gait aids
- ☐ Heat
- ☐ Ice
- ☐ Rest
- ☐ Physical therapy

ACTIVITIES OF DAILY LIVING:

Putting on socks and shoes is:

- ☐ No trouble
- ☐ Difficulty
- ☐ Unable to do without assistance

You can sit:

- ☐ In any chair for 1 hour
- ☐ In a high chair for ½ hour
- ☐ Unable to sit for ½ hour

You rise from a chair:

- ☐ Without using arms
- ☐ Using arms
- ☐ Unable to rise from a chair without assistance

You can use the stairs:

- ☐ Normally with one foot over the other
- ☐ Normally but using a rail
- ☐ By other method(s)
- ☐ Unable to do stairs

You can pick up an object from the floor:

- ☐ With NO trouble
- ☐ With difficulty
- ☐ Requiring support
- ☐ Unable to pick up objects from the floor

You use an assistive device to walk:

- ☐ Never
- ☐ Cane for long walks
- ☐ Cane at all times
- ☐ 1 Crutch
- ☐ 2 Crutches, 2 Canes, or Walker
- ☐ Unable to walk

You can carry objects:

- ☐ With no limit
- ☐ With significant limit

Are you able to drive?

- ☐ Yes
- ☐ No

How far do you walk before needing to rest/sit:

- ☐ Unlimited distances (without pain)
- ☐ For 30-60 minutes ($\geq$ 6 Blocks)
- ☐ Short distances outdoors (< 30 minutes, 2-3 blocks)
- ☐ Only indoors
- ☐ From bed to chair only