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:

+	

WHAT IS YOUR MAIN COMPLAINT?
BODY PART:

SELECT LATERALITY (Circle One)	
+	Right
+	Left
+	Both

INVOLVED AREA (Circle One)									
+	Neck	+	Shoulder	+	Arm				
+	Elbow	+	Forearm	+	Wrist				
+	Thumb	+	Index Finger	+	Long Finger	+	Ring Finger	+	Small Finger
+	Other:								

WHAT DOES IT FEEL LIKE? (PLEASE CHECK ALL THAT APPLY)

SYMPTOMS (Check all that apply):

- ☐ Numbness/Tingling
  If yes, is it constant or occasional?
- ☐ Stiffness
- ☐ Swelling
- ☐ Clicking/Popping
- ☐ Pain
  - ___Aching ___Constant
  - ___Dull ___Sporadic (Comes & goes)
  - ___Sharp ___Stabbing
- ☐ Wound
- ☐ Deformity
- ☐ Skin Lesion
- ☐ Mass
- ☐ Weakness
- ☐ Other_____

TIMING OF SYMPTOMS (Check all that apply):

- ☐ with activity
- ☐ with computer use
- ☐ after activity
- ☐ at work
- ☐ in the morning
- ☐ when driving
- ☐ in the evening
- ☐ on the phone
- ☐ at night
- ☐ constantly
- ☐ intermittently

HOW/WHEN DID IT OCCUR?

PLEASE CHECK ONE

☐ Sudden onset due to injury
Date of Injury _____

☐ Gradual onset due to injury
Date of Injury _____

☐ Sudden onset with no injury
How long has it bothered you? _____

☐ Gradual onset with no injury
How long has it bothered you? _____

If an injury occurred, what happened? Where?
WORK HOME CAR SCHOOL SPORTS OTHER_____
_____
_____

WHAT HAVE YOU DONE FOR IT?

What makes it better? _____
_____
_____

What makes it worse? _____
_____
_____

What medication have you taken for this problem?

___ Muscle relaxants
Which ones? _____
_____

___ Anti-Inflammatories
Which ones? _____
_____

___ Pain Medications
Which ones? _____
_____

Check box if have tried:

- ☐ Injections
- ☐ Physical therapy
- ☐ Splinting
- ☐ Tens unit

What surgeries have you had for this problem? _____
_____
_____

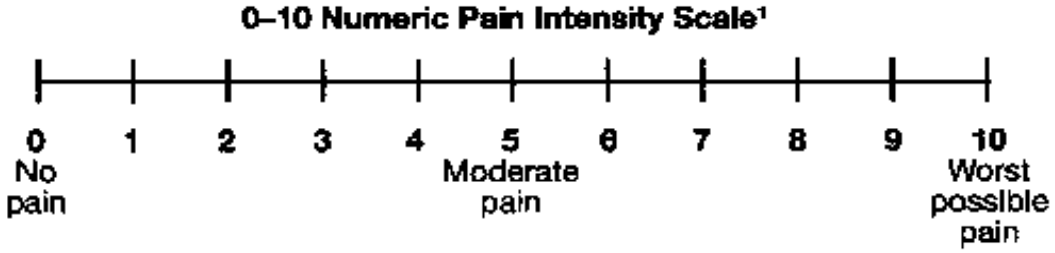
HAVE YOU HAD ANY STUDIES FOR THIS PROBLEM? (MRI, X-Ray, CT Scan, etc.) ☐ YES ☐ NO

_____

IF YOU WANT A FAMILY MEMBER TO HAVE ACCESS TO SPEAK TO OUR STAFF ABOUT YOUR HEALTHCARE, PLEASE INDICATE PERSON'S NAME AND RELATIONSHIP HERE.

_____

Please rate the amount of pain you have in your hand/arm in a typical day:



Please answer ALL questions, as best you can:

QuickDASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5