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? PLEASE CIRCLE SIDE AND BODY PART

BODY PART:

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

INVOLVED AREA (Circle One)	
+	Foot
+	Ankle
+	Toe(s)
+	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 ___Intermittent (Comes & goes)
  - ___Sharp ___Stabbing
- ☐ Other________________________________
- ☐ Wound
- ☐ Deformity
- ☐ Skin Lesion
- ☐ Mass
- ☐ Weakness

TIMING OF SYMPTOMS (Check all that apply):

- ☐ with activity
- ☐ after activity
- ☐ at work
- ☐ in the morning
- ☐ at night
- ☐ in the evening
- ☐ constantly
- ☐ intermittently

PAIN SEVERITY: (Choose One)

- ☐ Mild
- ☐ Moderate
- ☐ Severe

PAIN STATUS: (Choose One)

- ☐ Better
- ☐ No Change
- ☐ Improving
- ☐ Worsening

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
- ☐ Immobilization/Bracing

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.

____