

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:

+	
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WHAT IS YOUR MAIN COMPLAINT?

PLEASE CIRCLE SIDE AND BODY PART

BODY PART:

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

INVOLVED AREA (Circle One)							
+ Hand	+ Wrist	+ Elbow	+ Shoulder				
+ Foot	+ Ankle	+ Knee	Other:				
+ Hip	+ Back	+ Neck					

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

SYMPTOMS (Check all that apply):

- Numbness/Tingling
 - Stiffness
 - Swelling
 - Clicking/Popping
 - Pain
 - ___ Aching ___ Constant
 - ___ Dull ___ Intermittent (Comes & goes)
 - ___ Sharp ___ Stabbing
 - Other _____
- Wound
 - Deformity
 - Skin Lesion
 - Mass
 - Weakness

- | | |
|---|---|
| <u>TIMING OF SYMPTOMS (Check all that apply):</u> | |
| <input type="checkbox"/> with activity | <input type="checkbox"/> at night |
| <input type="checkbox"/> after activity | <input type="checkbox"/> in the evening |
| <input type="checkbox"/> at work | <input type="checkbox"/> constantly |
| <input type="checkbox"/> in the morning | <input type="checkbox"/> intermittently |

- | | |
|---------------------------------------|---|
| <u>PAIN SEVERITY:</u>
(Choose One) | <u>PAIN STATUS:</u>
(Choose One) |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Better <input type="checkbox"/> Improving |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> No Change <input type="checkbox"/> Worsening |
| <input type="checkbox"/> Severe | |

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.