# 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**.
_____