

Duke Amputee Clinic at Patterson Place

Patient Registration Form

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

PATIENT INFORMATION

NAME: _____ TODAY'S DATE: _____

BIRTHDATE: _____ AGE: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY STATE ZIP

OCCUPATION: _____

EMPLOYER: _____

PHONE #: _____

WORK PHONE #: _____

CELL PHONE #: _____

E-MAIL ADDRESS: _____

SPOUSE/PARENT: _____

INSURANCE PRIMARY: _____

SUBSCRIBER: _____

SECONDARY: _____

SUBSCRIBER: _____

OTHER INSURANCE: _____

SUBSCRIBER: _____

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 a pharmacy preference

ADDRESS: _____

CITY STATE ZIP

PHONE #: _____ FAX #: _____

HPI

Check reason for coming to clinic today:

- First post-operative appointment
- Requesting education, services or consultation
- Other _____

Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Live alone | <input type="checkbox"/> Live in rehab facility |
| <input type="checkbox"/> Live with family | <input type="checkbox"/> Live in skilled nursing facility |
| <input type="checkbox"/> Live with spouse | <input type="checkbox"/> Live in home |
| <input type="checkbox"/> Live with child | <input type="checkbox"/> Live in apartment |
| <input type="checkbox"/> Live with friend | <input type="checkbox"/> Other _____ |

Please check all current equipment:

- | | |
|---|---|
| <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Electric wheelchair or scooter | <input type="checkbox"/> Bedside commode |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Shower bench |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Prostheses (specify) _____ |
| <input type="checkbox"/> Other _____ | |

Please check all rehab services you have had to date:

- Inpatient PT/OT
- Inpatient rehab
- Home health PT/OT
- Outpatient PT/OT
- Home health wound care

PAST MEDICAL HISTORY

- Right Handed Left Handed Ambidextrous

- AIDS/HIV Cancer-Breast Diabetes Hepatitis Sleep apnea
- Alcoholism Cancer-Colon Drug Abuse Kidney Disease Pacemaker
- Alzheimer's Cancer-Lung GERD Osteoarthritis High blood pressure
- Anemia Cancer-Prostate Gout Rheumatoid Arthritis Chest Pain
- Asthma COPD Heart Disease Seizures Sickle Cell Anemia
- Blood Clots Depression Hypertension Ulcers Stroke
- OTHER: (Thyroid, Heart attack, reflux, use of blood thinners) _____

FEMALE PATIENTS ONLY: Are you pregnant, or is there a chance you may be pregnant? _____
 First day of last menstrual period _____

SURGICAL HISTORY

- Orthopaedic Surgeries _____
- Tonsillectomy, when? _____
- Appendectomy, when? _____
- Gall Bladder Removed, when? _____
- Hysterectomy, when? _____
- Other _____

CURRENT MEDICATIONS None

DRUG ALLERGIES None

FAMILY MEDICAL HISTORY (Mother, Father, Siblings, Grandparents)

Disease	Relationship to patient	Disease	Relationship to patient
<input type="checkbox"/> AIDS/HIV	_____	<input type="checkbox"/> Gout	_____
<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Alzheimer's	_____	<input type="checkbox"/> Hypertension	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Heart Attack	_____
Where? _____		<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Depression	_____		_____
<input type="checkbox"/> Diabetes	_____		_____
<input type="checkbox"/> Drug Abuse	_____		_____

SOCIAL HISTORY

Current Job: _____

Employer: _____

Marital Status: Single Married Domestic Partner Divorced Separated Widowed

Children: Sons _____ Daughters: _____
 How many? How many?

Tobacco: Circle one: Yes No Quit
Type: _____
 (Cigarettes, Cigars, Chewing, Pipe)
Packs/day _____
Years smoked _____
Year quit _____

Alcohol: Circle one: Yes No Quit
Amount _____
Frequency _____
Year quit _____

Illicit Drugs: Circle one Yes No Quit
Type _____
Years used _____
Year quit _____

Review of Systems

Constitutional

- Weight gain Insomnia
- Weight Loss Fatigue
- Fever Chills
- Weakness Night sweats
- Malaise

Respiratory

- Short of breath Wheezing
- Cough TB Exposure
- Breathing pain

Gastrointestinal

- Loss of appetite Abdominal pain
- Nausea Heartburn
- Vomiting Blood Jaundice
- Diarrhea
- Constipation
- Dark stool Blood

Dermatological

- Contact allergy
- Rashes

Metabolic

- Cold intolerant Heat Intolerant

Immunological

- Asthma Bee sting allergy
- Contact dermatitis Food allergies
- Type? Type of food?

HEENT

- Headaches Vertigo/World spinning
- Double vision Difficulty swallowing
- Blurred vision
- Hearing Loss
- Ringing in ears

Cardiovascular

- Chest pain
- Feel heart beating hard
- Fainting spells

Genitourinary

- Frequency
- Urgency
- Blood in urine
- Frequent night-time urination
- Incontinence

Neurological

- Seizures Loss of coordination
- Tremors Difficulty walking
- Numbness/Tingling Memory loss
- Dizziness/Lightheaded Depression

Hematologic

- Easy bruising Easy bleeding

Reproductive

- Pain interfering with sex

Other
