

# 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: \_\_\_\_\_

BIRTHDAY: \_\_\_\_\_ AGE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

(If retired, please indicate this AND list your occupation prior to retirement)

CITY STATE ZIP

EMPLOYER: \_\_\_\_\_

PHONE #: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

CELL PHONE #: \_\_\_\_\_

SPOUSE/PARENT NAME: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY STATE ZIP

PHONE #: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY STATE ZIP

PHONE #: \_\_\_\_\_

PREFERRED PHARMACY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY STATE ZIP

PHONE #: \_\_\_\_\_

I give permission for my physician to access my medication history from the National Surescripts Database.

Sign \_\_\_\_\_ Date \_\_\_\_\_

## ORTHOPAEDIC HISTORY

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ PAIN SCORE: 0 1 2 3 4 5 6 7 8 9 10

WHAT IS YOUR MAIN COMPLAINT? \_\_\_\_\_

BODY PART:            RIGHT, LEFT, or BOTH            KNEE            HIP

HAVE YOU HAD PREVIOUS SURGERY ON YOUR HIPS or KNEES?    YES    NO

If yes, please specify:

Right/ Left	SURGERY	DATE	PHYSICIAN	HOSPITAL	CITY/STATE

SYMPTOMS: (circle what applies) PAIN or SWELLING or INSTABILITY or \_\_\_\_\_

WHEN JOINT IS PAINFUL, IS IT:

- Slight, Occasional (no compromise on activities)
- Mild (makes no effect on normal daily activities)
- Moderate (able to be active but has to make modifications and/or give up activities)
- Severe (major pain with significant limitations)
- Totally Disabled (crippled, bedridden)

HOW/WHEN DID IT OCCUR? (Please check one)

- Sudden onset due to injury (Date of Injury \_\_\_\_\_)
- Sudden onset with no injury (How long has it bothered you? \_\_\_\_\_)
- Gradual onset due to injury (Date of Injury \_\_\_\_\_)
- Gradual onset with no injury (How long has it bothered you \_\_\_\_\_)

CURRENTLY SYMPTOMS BOTHER YOU WHEN: (Check all that apply)

- Constantly
- Unpredictable, without relation to activity
- With normal daily activities
- During higher levels of activity
- At night in bed (keeps you awake)
- At rest ONLY
- Bending/squatting
- Going up and/or down stairs
- With recreational sports
- With competitive sports

DO YOU USE:

- Cane for long walks
- Cane at all times
- 1 Crutch
- 2 Crutches, 2 Canes, or Walker
- Unable to walk
- Do not need any assistive device to walk

## ORTHOPAEDIC HISTORY

### WHAT MAKES THE PAIN BETTER? (Check/Describe all that apply)

- Medications (Name ALL medications \_\_\_\_\_ )
- Cortisone Injection(s) (When was the last injection? \_\_\_\_\_ )
- Synvisc/Hyaluronic acid injections
- Oral Steroids (ex. Prednisone)
- Gait Aid (ex. Cane, Crutches, Walker, etc) Which one(s)? \_\_\_\_\_
- Brace/Splint
- Exercise
- Heat
- Ice
- Physical Therapy
- NO RELIEF

### HOW FAR DO YOU WALK BEFORE NEEDING TO REST/SIT:

- Unlimited distances
- For 30-60 minutes ( $\geq 6$  Blocks)
- Short distances outdoors (< 30 minutes, 2-3 blocks)
- Only indoors
- From bed to chair only

### ACTIVITIES OF DAILY LIVING:

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#### Putting on socks & shoes is:

- Easy
- Difficult
- Unable to do without assistance

#### You can carry objects:

- With NO limit
- With significant limit

#### You can go up and/or down stairs:

- Normally without using the rail
- Normally (1 foot over other) with USING the rail
- Any other method (ex. One step at a time)
- Unable to do stairs

#### Are you able to drive?

- YES     NO

#### You rise from a chair:

- Without using arms
- Using arms
- Unable to rise from a chair without assistance

#### You can sit:

- In any chair for 1 hour
- In a high chair for  $\frac{1}{2}$  hour
- Unable to sit for  $\frac{1}{2}$  hour

#### You can pick up an object from the floor:

- With NO trouble
- With difficulty
- Requiring support
- Unable to lift object

**ORTHOPAEDIC HISTORY**

**PAST MEDICAL HISTORY**

- |                                       |  |  |   |  |
|---------------------------------------|--|--|---|--|
| <input type="checkbox"/> Right Handed | <input type="checkbox"/> Left Handed                         | <input type="checkbox"/> Ambidextrous  |   |  |
| <input type="checkbox"/> AIDS/HIV     | <input type="checkbox"/> Cancer-Breast                       | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Sleep apnea         |
| <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Cancer-Colon                        | <input type="checkbox"/> Drug Abuse    | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Pacemaker           |
| <input type="checkbox"/> Alzheimer's  | <input type="checkbox"/> Cancer-Lung                         | <input type="checkbox"/> GERD          | <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Cancer-Prostate                     | <input type="checkbox"/> Gout          | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Chest Pain          |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> COPD                                | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Sickle Cell Anemia  |
| <input type="checkbox"/> Blood Clots  | <input type="checkbox"/> Depression                          | <input type="checkbox"/> Hypertension  | <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> 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)

<b>Disease</b>	<b>Relationship to patient</b>	<b>Disease</b>	<b>Relationship to patient</b>
<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	_____		_____

# ORTHOPAEDIC HISTORY

## 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 \_\_\_\_\_

**Activity Level:**  
How many times a week do you exercise? \_\_\_\_\_

## Review of Systems

### ***Constitutional***

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

### ***Respiratory***

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

### ***Gastrointestinal***

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

### ***Dermatological***

- Contact allergy
- Rashes

### ***Metabolic***

- Cold intolerant
- Heat Intolerant

### ***Immunological***

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

### ***HEENT***

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

### ***Cardiovascular***

- Chest pain
- Feel heart beating hard
- Fainting spells

### ***Genitourinary***

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

### ***Neurological***

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

### ***Hematologic***

- Easy bruising
- Easy bleeding

### ***Reproductive***

- Pain interfering with sex

### ***Other***

\_\_\_\_\_