

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: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY STATE ZIP

OCCUPATION: _____

EMPLOYER: _____

PHONE #: _____

WORK PHONE #: _____

CELL PHONE #: _____

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 #: _____

APPOINTMENT TODAY IS WITH DR. PAREKH.

WHAT IS YOUR MAIN COMPLAINT?

PLEASE CIRCLE SIDE AND BODY PART

BODY PART: RIGHT LEFT BOTH

FOOT ANKLE

WHAT DOES IT FEEL LIKE?

PLEASE CHECK ALL THAT APPLY

SYMPTOMS:

- NUMBNESS/TINGLING
If yes, is it constant or occasional?
- STIFFNESS
- SWELLING
- CLICKING/POPPING

PAIN:

QUALITY

- ACHING DULL THROBBING
- BURNING SHARP STABBING

DURATION

- CONSTANT INTERMITTENT

TIMING

- AM NIGHT ALL DAY

SEVERITY

- MILD MODERATE SEVERE

STATUS

- BETTER IMPROVING
- NO CHANGE 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?

CHECK BOX IF HAVE TRIED:

____ MUSCLE RELAXANTS
Which ones? _____

- INJECTIONS
- PHYSICAL THERAPY
- SPLINTING
- TENS UNIT
- IMMOBILIZATION /BRACING

____ ANTI-INFLAMMATORIES
Which ones? _____

____ PAIN MEDICATIONS
Which ones? _____

WHAT SURGERIES HAVE YOU HAD FOR THIS PROBLEM? _____

HAVE YOU HAD ANY STUDIES FOR THIS PROBLEM? (MRI, X-Ray, CT Scan, etc.) _____

PAST MEDICAL HISTORY

Right Handed Left Handed

- | | | | | |
|--------------------------------------|--|--|---|--|
| <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 |
- OTHER: (Thyroid, Heart attack, etc) _____

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 _____

Activity Level:
How many times a week do you exercise? _____

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

Patient ID:	Date and visit (e.g., baseline, 6-month follow-up, etc):
Site name:	CRA name:

APPENDIX G - SF-12 FORM

1. In general, would you say your health is: **(Check one)**

Excellent	Very good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions are about activities you might do during a typical day. Does your **health now limit you** in these activities? If so, how much? **(Check one)**

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.

Limited a lot	Limited a little	Not limited at all
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Climbing several flights of stairs.

Limited a lot	Limited a little	Not limited at all
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the **past four weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?** **(Check one)**

4. Accomplished less than you would like. Yes No

5. Had difficulty performing the work or other activities, for example, it took extra effort. Yes No

During the **past four weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of emotional problems** (such as feeling depressed or anxious)? **(Check one)**

6. Accomplished less than you would like. Yes No

Patient ID:	Date and visit (e.g., baseline, 6-month follow-up, etc):
Site name:	CRA name:

7. Didn't do work or other activities as carefully as usual. Yes No
8. During the past four weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? **(Check one)**

Not at all Slightly Moderately Quite a bit Extremely

9. During the past four weeks, how much did pain interfere with your normal activities (including both work outside the home, housework and family activities)? **(Check one)**

Not at all Slightly Moderately Quite a bit Extremely

These questions are about how you feel and how things have been with you **during the past four weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past four weeks**:

10. Have you felt calm and peaceful? **(Check one)**

All of the time Most of the time A good bit of the time Some of the time A little of the time None of the time

11. Did you have a lot of energy? **(Check one)**

All of the time Most of the time A good bit of the time Some of the time A little of the time None of the time

12. Have you felt downhearted and blue? **(Check one)**

All of the time Most of the time A good bit of the time Some of the time A little of the time None of the time