

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

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

**Who is your appointment with today?**

Dr. Almekinders

Dr. Kelley

Dr. Minchew

Dr. Schreyack

Dr. Tawney

Dr. Richard



**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)

<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	_____		_____

**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***

\_\_\_\_\_

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**MEDICAL IMAGES on Film** (X-rays, MRI, CT, or Bone Scans):

If you bring medical images with you, they will be filed in the NCOC Radiology Department after your Provider has reviewed them. We will keep these films on file for **up to six months**. After six months, original films will be returned to the place of origin. Copies of films will be discarded.

**You may request to pick up your images anytime before the six month period.**

**MEDICAL IMAGES on CD:**

We keep a file of CD's with medical images. At your request, we can return the CD to you on your next visit.

Signature \_\_\_\_\_ Date \_\_\_\_\_