

North Carolina Orthopaedic Clinic

Patient Registration Form—Dr. Richard

FOR US TO BEST SERVE YOU, PLEASE COMPLETE AS FULLY AS YOU ARE ABLE AND PRINT CLEARLY

PATIENT INFORMATION

NAME: _____

TODAY'S DATE: _____

BIRTHDATE: _____

SOCIAL SECURITY #: _____

ADDRESS: _____

INSURANCE PRIMARY: _____

CITY STATE ZIP

SUBSCRIBER: _____

HOME PHONE #: _____

SECONDARY: _____

CELL PHONE #: _____

SUBSCRIBER: _____

WORK PHONE #: _____

OTHER INSURANCE: _____

SPOUSE OR PARENT: _____
(circle which)

SUBSCRIBER: _____

PRIMARY CARE PROVIDER:

I don't have one

ADDRESS: _____

CITY STATE ZIP

PHONE #: _____ FAX #: _____

REFERRING HEALTHCARE PROFESSIONAL (MD, PA, PT, Chiropractor, etc.):

No one referred me

ADDRESS: _____

CITY STATE ZIP

PHONE #: _____ FAX #: _____

PREFERRED PHARMACY:

I don't have a preference

ADDRESS: _____

CITY STATE ZIP

PHONE #: _____ FAX #: _____

IF YOU WANT A FAMILY MEMBER TO HAVE ACCESS TO SPEAK TO OUR STAFF ABOUT YOUR HEALTHCARE, PLEASE INDICATE THAT PERSON'S NAME AND RELATIONSHIP HERE:

NAME: _____ RELATIONSHIP: _____

NAME: _____

PAST MEDICAL HISTORY

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

OTHER: _____

FEMALE PATIENTS ONLY: Is it possible you may be pregnant? _____ First day of last menstrual period _____

SURGICAL HISTORY (list all operations you have ever had in your life):

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

CURRENT MEDICATIONS None

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DRUG ALLERGIES None Known

_____	_____	_____
_____	_____	_____

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

- | Disease | Relationship to patient |
|--------------------------------------|-------------------------|
| <input type="checkbox"/> AIDS/HIV | _____ |
| <input type="checkbox"/> Alcoholism | _____ |
| <input type="checkbox"/> Alzheimer's | _____ |
| <input type="checkbox"/> Anemia | _____ |
| <input type="checkbox"/> Arthritis | _____ |
| <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Cancer | _____ |
| Which kind? _____ | |
| <input type="checkbox"/> Depression | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Drug Abuse | _____ |

- | Disease | Relationship to patient |
|---|-------------------------|
| <input type="checkbox"/> Gout | _____ |
| <input type="checkbox"/> Heart Disease | _____ |
| <input type="checkbox"/> Hypertension | _____ |
| <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Heart Attack | _____ |
| <input type="checkbox"/> Other: _____ | _____ |

NAME: _____

SOCIAL HISTORY

Current Job (Adult) or Current Grade in School (Pediatric): _____

Employer (Adult) or School (Pediatric): _____

Marital Status: Single Married Domestic Partner Divorced Separated Widowed

Children: None Number of living sons: _____ Number of living daughters: _____

Tobacco: Yes No Quit

Alcohol: Yes No Quit

Type: _____

Amount _____

(Cigarettes, Cigars, Pipe, Smokeless)

Frequency _____

Packs/day _____

Year quit _____

Years smoked _____

Year quit _____

Other Non-Prescription Drugs: Yes No Quit

Type _____

Years used _____

Year quit _____

Activity Level:

How many times a week, on average, do you exercise? _____ What kind? _____

Are you presently experiencing any of these symptoms—OTHER THAN THOSE SYMPTOMS RELATED TO TODAY'S VISIT

Constitutional

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

HEENT

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

Respiratory

- Shortness of breath
- Cough
- Pain with breathing
- Wheezing
- TB Exposure

Cardiovascular

- Chest pain
- Feel heart beating fast or hard
- Fainting spells

Gastrointestinal

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

Genitourinary

- Increased frequency
- Urinary urgency
- Incontinence
- Blood in urine
- Frequent night-time urination

Dermatological

Metabolic

- Rashes
- Cold intolerant
- Heat Intolerant ***Hematologic***

Neurological

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

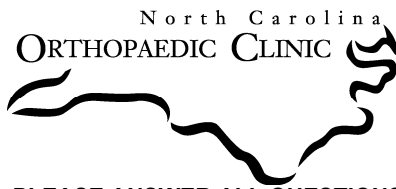
Immunological

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

Other

- Easy bruising
- Easy bleeding
- Pain interfering with sex

Other



New Problem Questionnaire

Patient Name: _____

Age: _____ Today's Date: ___/___/___

Handedness: Right Left

No

PLEASE ANSWER ALL QUESTIONS AS BEST YOU CAN

Are you presently working? Yes

What job do you do (or grade in school)? _____

Who is your employer (or school name)? _____

How long have you worked here? _____

Are you claiming Workers' Compensation for this problem? Yes No

Chief Complaint (MAIN symptom, only ONE please):

- | | | | | |
|--------------------------------|------------------------------------|--------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Swelling | <input type="checkbox"/> Mass | <input type="checkbox"/> Numbness / Tingling |
| <input type="checkbox"/> Wound | <input type="checkbox"/> Deformity | <input type="checkbox"/> Skin Lesion | <input type="checkbox"/> Weakness | <input type="checkbox"/> Other _____ |

Severity: Mild Moderate Severe Variable _____

Involved Side: Right Left Both

Involved Area:

- | | | | | | |
|-------------------------------|-----------------------------------|---------------------------------------|--------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Arm | <input type="checkbox"/> Elbow | <input type="checkbox"/> Forearm | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Thumb | <input type="checkbox"/> Index Finger | <input type="checkbox"/> Long Finger | <input type="checkbox"/> Ring Finger | <input type="checkbox"/> Small Finger |

***IF YOUR SYMPTOMS INCLUDE PAIN, NUMBNESS OR TINGLING, OR DECREASED SENSATION, PLEASE ADDRESS THE SYMPTOM DIAGRAM ON THE BACK OF THIS PAGE.**

The onset was: Sudden, beginning on ___/___/___
 Gradual, first starting _____ weeks ago months ago years ago

How did it happen or start? _____

It feels:

- | | | | | |
|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Tingling | <input type="checkbox"/> Cramping | <input type="checkbox"/> Deep |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Aching | <input type="checkbox"/> Burning | <input type="checkbox"/> | <input type="checkbox"/> Superficial |

Symptoms Occur:

- | | | | | | |
|--|---|---|---|-----------------------------------|---|
| <input type="checkbox"/> with activity | <input type="checkbox"/> after activity | <input type="checkbox"/> in the morning | <input type="checkbox"/> in the evening | <input type="checkbox"/> at night | <input type="checkbox"/> constantly |
| <input type="checkbox"/> with computer use | <input type="checkbox"/> at work | <input type="checkbox"/> when driving | <input type="checkbox"/> on the phone | <input type="checkbox"/> | <input type="checkbox"/> intermittently |

Associated Symptoms:

- | | | | | |
|--------------------------------|------------------------------------|--------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Swelling | <input type="checkbox"/> Mass | <input type="checkbox"/> Numbness / Tingling |
| <input type="checkbox"/> Wound | <input type="checkbox"/> Deformity | <input type="checkbox"/> Skin Lesion | <input type="checkbox"/> Weakness | <input type="checkbox"/> Other _____ |

What makes it worse? _____

Does anything make it better? _____

Have you had previous surgery for this problem?

- No
 Yes--details: _____

Treatment, other than surgery, you have had for this problem:

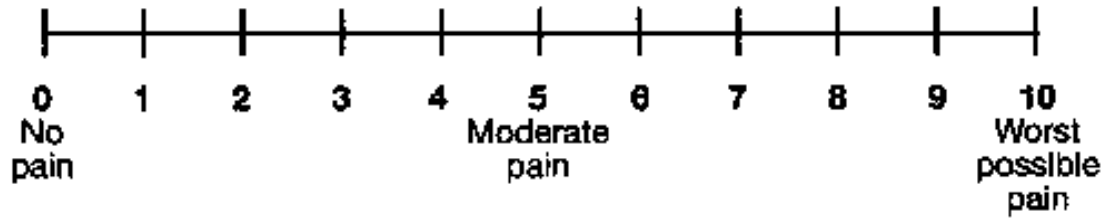
- | | | | | |
|---|-------------------------------|-------------------------------------|----------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Rest | <input type="checkbox"/> Ice / Heat | <input type="checkbox"/> Therapy | <input type="checkbox"/> Splint / Cast |
| <input type="checkbox"/> Medications: _____ | | | | |

Previous studies you have had for this problem:

- | | | | | |
|-------------------------------|---------------------------------|------------------------------|--|---------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> X-rays | <input type="checkbox"/> MRI | <input type="checkbox"/> Nerve Studies | <input type="checkbox"/> Other: _____ |
|-------------------------------|---------------------------------|------------------------------|--|---------------------------------------|

Please rate the amount of pain you have in your hand/arm in a typical day:

0-10 Numeric Pain Intensity Scale¹



Please answer ALL questions, as best as you can:

QuickDASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, <i>to what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. (circle number)

	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5