

DUKEMEDICINE

DUKE ORTHOPAEDICS OF RALEIGH

Patient Registration Form

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: _____

EMAIL ADDRESS: _____

SPOUSE/PARENT: _____

INSURANCE PRIMARY: _____

SUBSCRIBER: _____

SECONDARY: _____

SUBSCRIBER: _____

OTHER INSURANCE: _____

SUBSCRIBER: _____

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

CITY STATE ZIP

PHONE #: _____

REFERRING PHYSICIAN: _____

ADDRESS: _____

CITY STATE ZIP

PHONE #: _____

PREFERRED PHARMACY: _____

ADDRESS: _____

CITY STATE ZIP

PHONE #: _____

Orthopaedic Initial History Survey

Age _____ F M Height _____ / _____ Weight _____ Did you bring x-rays? Y N Labs Y N

Who requested that you visit this office? Doctor (Name) _____ Self-Referral Attorney _____

What is the main reason for this visit? _____

What body part is involved? If multiple, choose worst						
Neck <input type="checkbox"/>	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Pelvis <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L
Back <input type="checkbox"/> Mid <input type="checkbox"/> Lower	Arm <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Finger <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Toe <input type="checkbox"/> R <input type="checkbox"/> L

How long has this problem been present? _____ Days Weeks Months Years

Was onset? Gradual or Sudden

Are you right or left handed? Right Left Ambidextrous

Did you have an injury? Yes No If so, what was it? _____

Date of Injury? _____

At work? Yes No

In a motor vehicle accident? Yes No

Litigation Pending? Yes No

Please check the box below which best describes your problem:

The pain is Constant Comes and goes (Intermittent)

What severity level would you use to describe your pain? (On a scale of 0-10: 0=no pain 10=worst pain)

0 1 2 3 4 5 6 7 8 9 10

How would you describe the pain associated with this problem/injury? Check all that apply.

- | | |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Sharp |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dull | |
| <input type="checkbox"/> Excruciating | |
| <input type="checkbox"/> Pulsating | |

What activities make the problem worse?

- | | | |
|--|-----------------------------------|---|
| <input type="checkbox"/> Grasping | <input type="checkbox"/> Standing | <input type="checkbox"/> Typing/Repetitive |
| <input type="checkbox"/> Gripping | <input type="checkbox"/> Walking | <input type="checkbox"/> Squatting/Kneeling |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Stairs | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Overhead Reaching | <input type="checkbox"/> Twisting | |

Do any of the following improve the problem?

- | | |
|---|--|
| <input type="checkbox"/> Using a Brace/Cane | <input type="checkbox"/> Resting the Area |
| <input type="checkbox"/> Cold Application | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Heat Application | <input type="checkbox"/> Cortisone Injection |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Other _____ |

Have you had other symptoms with this problem?

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Feeling of Giving Way | <input type="checkbox"/> Tenderness |
| <input type="checkbox"/> Locking | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Popping | |

PAST MEDICAL HISTORY

- NONE
- AIDS/HIV
- Alcoholism
- Alzheimer's
- Anemia
- Asthma
- OTHER: _____
- Cancer _____
- COPD
- Depression
- Diabetes
- Drug Abuse
- DVT/PE
- GERD/Reflux
- Gout
- Heart Disease
- Hepatitis
- High Blood Pressure
- Kidney Disease
- Osteoporosis
- Pacemaker
- Rheumatoid Arthritis
- Seizures
- Sickle Cell Anemia
- Sleep Apnea
- Stroke
- Ulcers
- Use of Blood Thinners

SURGICAL HISTORY

Have you ever had any of the following surgeries? Indicate the year of the surgery:

- Appendectomy _____
- Gall Bladder _____
- Hernia repair _____
- Hysterectomy _____
- Arthroscopic Surgery _____
- Spine Surgery _____
- Open Heart/By-pass _____
- Orthopaedic Surgery _____
- Prostate Surgery _____
- Other (type & year) _____

Have you ever had a reaction to surgery or anesthesia? Yes No

Describe _____

MEDICATIONS

What medications are you currently taking? Please include both prescription and non-prescription medications.

Medications	Dose	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Are you allergic to any of the following? Please describe the reaction.

- NO KNOWN ALLERGIES**
- Adhesive Tape _____
- Codeine _____
- Erythromycin _____
- Iodine/Betadine _____
- Morphine _____
- Penicillin _____
- Radiographic dyes _____
- Sulfa _____
- Tetracycline _____
- Latex _____
- Other _____

SOCIAL HISTORY

Current Job: _____

Marital Status: Single Married Domestic Partner Divorced Separated Widowed

Children: Yes No

Tobacco : Yes No Quit

Alcohol: Yes No Quit

Type: _____

Amount _____

(Cigarettes, Cigars, Chewing, Pipe)

Frequency _____

Packs/day _____

Year quit _____

Years smoked _____

Year quit _____

Do you now or have you ever used drugs? Yes No Quit

Type _____

Years used _____

Year quit _____

Activity Level:

How many times a week do you exercise? _____

FAMILY HISTORY

Have any direct relatives had any of the following disorders? If so, which relative?

Arthritis _____ Heart Disease _____

Cancer _____ High Blood Pressure _____

Diabetes _____

Review of Systems

Constitutional

- Weight gain
- Weight Change
- Fever
- Chills
- Night Sweats

Head-Ear-Eyes-Nose-Throat

- Headaches
- Double Vision
- Ringing in Ears
- Difficulty Swallowing

Cardiovascular

- Chest pain
- Feel heart beating hard
- Fainting spells

Genitourinary

- Frequency
- Urgency
- Blood in urine

Musculoskeletal

- Gout
- Osteoporosis

Dermatological

- Rashes

Respiratory

- Short of breath
- Cough
- Wheezing

Gastrointestinal

- Nausea
- Dark Stool or Blood Stool
- Heartburn

Vascular

- DVT/Phlebitis
- Open Wounds That Don't Heal

Neurological

- Seizures
- Tremors
- Loss of coordination

Hematologic

- Easy bruising
- Easy bleeding

Everything I have answered above is true and correct to the best of my knowledge.

Patient Signature: _____ Date __/__/__

Reviewed by MD _____ Date __/__/__

Reviewed by MD: _____ Date __/__/__

Reviewed by MD _____ Date __/__/__