SOUTHEASTERN ORTHOPEDICS SHOULDER CENTER

Patient Registration Form

FOR US TO PROCESS YOUR CHART, PLEASE COMPLETE FULLY AND PRINT CLEARLY

PATIENT INFORMATION:

NAME: ____ TODAY'S DATE: ________________________________

BIRTHDATE: ______________________AGE: ________ HOME PHONE #: ________________________________

ADDRESS: ______________________________________ CELL PHONE #: ________________________________

______________________________________ ________ EMAIL:____
CITY STATE ZIP

SOCIAL SECURITY #: ______________________________

EMPLOYMENT INFORMATION:

OCCUPATION: ____________________________________ EMPLOYER: ____________________________________

WORK PHONE #: __________________________________

PAYOR INFORMATION:

INSURANCE PRIMARY: ____________________________ SECONDARY INSURANCE: ______________________________
Subscriber name: ______________________________ Subscriber Name: ______________________________
Subscriber Social Security: ____________________Subscriber Social Security: ______________________
Subscriber Date of birth: ______________________ Subscriber Date of Birth: ______________________

Body Part: ☐ **Left Shoulder** ☐ **Right Shoulder** ☐ **Bilateral Shoulders** **Onset of pain:** _____/_____/_____

HT __________ **WT** ___________ **Pain Level (0-10** [no pain] **–** [worst pain]**)** ________

SOCIAL INFORMATION:

RACE (Check One): ☐ **Caucasian** ☐ **African-American** ☐ **Alaskan-Native** ☐ **American-Indian** ☐ **Asian** ☐ **Hawaii-Pacific** ☐ **Multi-Racial** ☐ **Unavailable** ☐ **Declined** ☐ **All Other**________________________________

ETHNICITY (Check One): ☐ **Hispanic or Latino** ☐ **Unavailable** ☐ **Declined** ☐ **Other**___________________________

LANGUAGE (Check One): ☐ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Other**______________________________________

MARITAL STATUS (Check One): ☐ **Single** ☐ **Married** ☐ **Domestic Partner** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

CHILDREN: SONS? ☐ **Yes** ☐ **No** DAUGHTERS? ☐ **Yes** ☐ **No**
How Many_______ How Many________

PARENT NAME (If a Minor): ____

EMERGENCY CONTACT: ____
Name Phone #

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 #: ____

How comfortable are you filling out forms?

_____ Extremely _____ Quite a bit _____ Somewhat _____ A little bit _____ Not at all

How do you prefer to learn new concepts? (You may select more than one learning style)

☐ Audio ☐ Reading ☐ Demonstration ☐ Explanation ☐ Visuals

☐ Hands On ☐ Class ☐ Group Session ☐ Role Play ☐ Other ______________________________

CURRENT MEDICATIONS ☐ **None**

________________________________ ________________________________ ________________________________
________________________________ ________________________________ ________________________________
________________________________ ________________________________ ________________________________
________________________________ ________________________________ ________________________________

PREFERRED PHARMACY: ____

☐ **I don't have one**

ADDRESS: ____

____
CITY STATE ZIP

PHONE #: ____________________________ FAX #: ____________________________

DRUG ALLERGIES ☐ **None**

Allergy:________________ Allergy:__________________ Allergy:________________ Allergy:________________
Reaction: _______________ Reaction: _________________ Reaction: _______________ Reaction: _______________

PAST MEDICAL HISTORY: (Check All that Apply) ☐All Negative

Alcohol abuse	+	Gout	+	Osteoarthritis	+
Anemia	+	Heart Disease	+	Prostate cancer	+
Asthma	+	Hepatitis	+	Rheumatoid arthritis	+
Breast cancer	+	HIV/AIDS	+	Seizures	+
Colon cancer	+	Hyperlipidemia	+	Sickle cell anemia	+
COPD	+	Hypertension	+	Sleep apnea	+
Depression	+	Kidney disease	+	Stroke	+
Diabetes Mellitus	+	Lung cancer	+	Ulcers	+
GERD	+	Lupus	+	OTHER:	+
	+		+		+

PAST SURGICAL HISTORY: (Check All that Apply) ☐All Negative

		Date:	**Laterality:**			**Date:**	**Laterality:**
Appendectomy	+			Shoulder joint replacement	+		(L) (R)
Back surgery	+			Shoulder arthroscopy	+		(L) (R)
Cholecystectomy	+			Mastectomy	+		(L) (R)
Coronary angioplasty	+			Pacemaker	+		
C-Section	+			Tonsillectomy	+		
Fracture surgery	+		(L) (R)	Tubal ligation	+		
Hernia repair	+		(L) (R)	Vasectomy	+		
Hysterectomy	+						

FAMILY MEDICAL HISTORY: (Check All that Apply) ☐ All Negative

	Alcohol Abuse	Anemia	Asthma	Breast Cancer	Colon Cancer	COPD	Depression	Diabetes	Gout	Heart Disease	Hepatitis	HIV	Hypertension	Hyperlipidemia	Kidney Cancer	Lung Cancer	Lupus	Osteoarthritis	Prostate Cancer	Reflux Disease	Rheum. Arthritis	Seizures	Sickle Cell Anemia	Sleep Apnea	Stroke	Ulcers
Mother																										
Father																										
Sister																										
Brother																										
Daughter																										
Son																										
Mat. Aunt																										
Mat. Uncle																										
Pat. Aunt																										
Pat. Uncle																										
MGM																										
MGF																										
PGM																										
PGF																										

Other: ____

☐ **Adopted** ☐ **Family History Unknown**

SOCIAL HISTORY

Alcohol Use (Check One): ☐ Yes ☐ Not Currently ☐ Never

How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 monthly ☐ 2-3 weekly ☐ 4 or more weekly

How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more

How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Drinks/Week: _______ Glasses of Wine
_______ Cans of Beer
_______ Shots of Liquor
_______ Drinks containing 0.5 oz of alcohol

Drug Use:

(Check One): ☐ **Yes** ☐ **No** **Frequency Per Week:** _____________ **Comments:**______________________

Type(s): ______________________________

Tobacco Use:

(Check One): ☐ **Current Everyday** ☐ **Current Someday** ☐ **Former** ☐ **Never**

Packs/day (Check One): ☐ 0.25 ☐ 0.5 ☐ 1.0 ☐ 1.5 ☐ 2.0 ☐ 3 ☐ Other:_____________

Quit Date:________________

Smokeless Tobacco (Check One): ☐ **Current User** ☐ **Former User** ☐ **Never**

Quit Date:________________

FALLS ASSESSMENT: Do you need assistance with ambulation (walking)? ☐ **Yes** ☐ **No**
Do you have a history of falling within the last 90 days? ☐ **Yes** ☐ **No**

REVIEW OF SYSTEMS: CHECK ***ONLY*** THOSE THAT APPLY

	Constitution
	Activity Change
	Apetite Change
	Chills
	Diaphoresis (ex. Sweating)
	Fatigue
	Fever
	Unexpected weight change

	HEENT
	Congestion
	Dental Problem
	Drooling
	Ear Discharge
	Ear Pain
	Facial Swelling
	Hearing Loss
	Mouth Sores
	Nosebleeds
	Rhinorrhea (runny nose)
	Sinus Pain
	Sinus Pressure
	Sneezing
	Sore Throat
	Tinnitus (ringing in ears)
	Trouble Swallowing
	Voice Change

	Eyes
	Eye Discharge
	Eye Itching
	Eye Pain
	Eye Redness
	Photophobia (light sens.)
	Visual Disturbance

	Respiratory
	Apnea
	Chest Tightness
	Choking
	Cough
	Shortness of Breath
	Stridor
	Wheezing

	Cardiovascular
	Chest Pain
	Leg Swelling
	Palpitations

	GI
	Abdominal Distention
	Abdominal Pain
	Anal Bleeding
	Blood in Stool
	Constipation
	Diarrhea
	Nausea
	Rectal Pain
	Vomiting

	Endocrine
	Cold Intolerance
	Heat Intolerance
	Polydipsia (ex. Thirst)
	Polyphagia (incr. appetite)
	Polyuria (ex. Urination)

	GUD
	Difficulty Urinating
	Dysuria
	Enuresis
	Dyspareunia
	Flank Pain
	Frequency
	Genital Sore
	Hematuria
	Menstrual Problem
	Pelvic Pain
	Vaginal Bleeding
	Vaginal Discharge
	Vaginal Pain
	Penile Discharge
	Penile Pain
	Penile Swelling
	Scrotal Swelling
	Testicular Pain

	Muscular
	Arthralgia (joint pain)
	Back Pain
	Gait Problem
	Joint Swelling
	Myalgias (muscle pain)
	Neck Pain
	Neck Stiffness

	Skin
	Color Change
	Pallor
	Rash
	Wound

	Allergy/Immuno
	Env. Allergies
	Food Allergies
	Immunocompromised

	Neurological
	Dizziness
	Facial Asymmetry
	Headaches
	Lightheadedness
	Numbness
	Seizures
	Speech Difficulty
	Syncope
	Tremors
	Weakness

	Hematologic
	Adenopathy
	Bruises/Bleeds Easily

	Psychiatric
	Agitation
	Behavior Problem
	Confusion
	Decr. Concentration
	Dysphoric Mood
	Hallucinations
	Hyperactive
	Nervous/Anxious
	Self-Injury
	Sleep Disturbance
	Suicidal Ideas