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: _____

_____ OCCUPATION: _____

CITY STATE ZIP

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 PARY

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?
___ MUSCLE RELAXANTS
Which ones? _____
_____
___ ANTI-INFLAMMATORIES
Which ones? _____
_____
___ PAIN MEDICATIONS
Which ones? _____
_____

CHECK BOX IF HAVE TRIED:
- □ INJECTIONS
- □ PHYSICAL THERAPY
- □ SPLINTING
- □ TENS UNIT
- □ IMMOBILIZATION /BRACING

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

□ 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, 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
□ AIDS/HIV	_____	□ Gout	_____
□ Alcoholism	_____	□ Heart Disease	_____
□ Alzheimer's	_____	□ Hypertension	_____
□ Anemia	_____	□ Kidney Disease	_____
□ Arthritis	_____	□ Osteoporosis	_____
□ Asthma	_____	□ Stroke	_____
□ Cancer	_____	□ Heart Attack	_____
Where? _____		□ Other _____	_____
□ Depression	_____	_____	_____
□ Diabetes	_____	_____	_____
□ 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
- ☐ Weight Loss
- ☐ Fever
- ☐ Weakness
- ☐ Malaise
- ☐ Insomnia
- ☐ Fatigue
- ☐ Chills
- ☐ Night sweats

Respiratory
- ☐ Short of breath
- ☐ Cough
- ☐ Breathing pain
- ☐ Wheezing
- ☐ TB Exposure

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

Dermatological
- ☐ Contact allergy
- ☐ Rashes

Metabolic
- ☐ Cold intolerant
- ☐ Heat Intolerant

Immunological
- ☐ Asthma
- ☐ Contact dermatitis
- ☐ Bee sting allergy
- ☐ Food allergies

Type? _____ Type of food? _____

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

Cardiovascular
- ☐ Chest pain
- ☐ Feel heart beating hard
- ☐ Fainting spells

Genitourinary
- ☐ Frequency
- ☐ Urgency
- ☐ Blood in urine
- ☐ Frequent night-time urination
- ☐ Incontinence

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

Hematologic
- ☐ Easy bruising
- ☐ Easy bleeding

Reproductive
- ☐ Pain interfering with sex

Other

_____