

# 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 \_\_/\_\_/\_\_