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: _____

INSURANCE PRIMARY: _____

SPOUSE/PARENT: _____ 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 ☐	Shoulder ☐R ☐L	Elbow ☐R ☐L	Hand ☐R ☐L	Pelvis ☐R ☐L	Knee ☐R ☐L	Foot ☐R ☐L
Back ☐Mid ☐Lower	Arm ☐R ☐L	Wrist ☐R ☐L	Finger ☐R ☐L	Hip ☐R ☐L	Ankle ☐R ☐L	Toe ☐R ☐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.

☐ Aching
☐ Burning
☐ Dull
☐ Excruciating
☐ Pulsating
☐ Sharp
☐ Other_____

What activities make the problem worse?

☐ Grasping
☐ Gripping
☐ Lifting
☐ Overhead Reaching
☐ Standing
☐ Walking
☐ Stairs
☐ Twisting
☐ Typing/Repetitive
☐ Squatting/Kneeling
☐ Other _____

Do any of the following improve the problem?

☐ Using a Brace/Cane
☐ Cold Application
☐ Heat Application
☐ Medication
☐ Resting the Area
☐ Sleeping
☐ Cortisone Injection
☐ Other _____

Have you had other symptoms with this problem?

☐ Bruising
☐ Feeling of Giving Way
☐ Locking
☐ Numbness/tingling
☐ Popping
☐ Swelling
☐ Tenderness
☐ Weakness
☐ Other _____

PAST MEDICAL HISTORY

☐ NONE
☐ AIDS/HIV
☐ Alcoholism
☐ Alzheimer's
☐ Anemia
☐ Asthma
☐ 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
☐ OTHER: _____

_____

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

Type: _____
(Cigarettes, Cigars, Chewing, Pipe)

Packs/day _____

Years smoked _____

Year quit _____

Alcohol: ☐ Yes ☐ No ☐ Quit

Amount _____

Frequency _____

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 _____
☐ Cancer _____
☐ Diabetes _____
☐ Heart Disease _____
☐ High Blood Pressure _____

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

Musculoskletal
☐ 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__/__/__