

Patient Registration

Patient Information

Last Name
First Name
Middle Name
Circle One: M F
Previous Last Name
Date of Birth
Social Security No.
Street Address
City/State/Zip
Home Phone No.
Work Phone No.
Mobile No.
Email Address:
Contact Preference
Language
Race
Ethnicity
Marital Status: S M Div Sep Wid
How did you hear about us?
Preferred Pharmacy
Preferred Pharmacy Address
Preferred Pharmacy Phone No.

If patient is a student or minor, please complete this section:

If patient is a student, list school
Guardian's Last Name
Guardian's First Name
Guardian's Middle Name
Emergency Contact Name
Emergency Contact Relation
Emergency Contact Home Phone
Emergency Contact Mobile Phone

Employer Information

Employer Name
Employer Phone No.
Occupation

Guarantor Information

Patient's Relationship to Guarantor
Guarantor's Last Name
Guarantor's First Name
Guarantor's Middle Name
Guarantor's Date of Birth
Address/Same as Patient?
Guarantor's Address
Guarantor's City/State/Zip
Guarantor's Social Security No.
Guarantor's Phone No.
Guarantor's Email Address
Guarantor's Employer
Guarantor's Employer Address
Guarantor's Employer Phone No.

Policy Holder's Name	Address	City	State	Zip	Insured's Date of Birth
Policy Holder's Social Security No.	Group Number		Policy Number		Medicare Number
Insurance Co. Name	Address	City	State	Zip	Phone
Additional Insurance					Medicaid Number

Patient's or authorized person's signature below. I understand that all fees owed to New Braunfels Orthopaedic Surgery & Sports Medicine are my personal responsibility. I also authorize the release of medical information.

Signature _____ Date: _____

Patient Intake Form

Name: _____ Email: _____ Date: _____

Height: _____ Weight: _____ Preferred Pharmacy: _____

For Staff Use Only:

Blood Pressure: _____ Pulse: _____ Age: _____ BMI: _____

What is the reason for today's visit? Please mark below:

€ Ankle	€ Hand/Fingers	€ Sacrum
€ C-Spine	€ Hip(s)	€ Shoulder
€ Coccyx	€ Knee	€ Sprain/Strain
€ Elbow/Forearm	€ L-Spine	€ Thigh
€ Follow-up	€ Lower Back	€ Toes
€ Foot	€ Lower Leg	€ Upper Arm
€ Forearm/Wrist	€ Neck	€ Upper Back
€ Fracture/Post-Op Follow-up	€ Ribs/Chest/Sternum	€ Wrist/Hand

(Circle all that apply to today's visit)

Hand Dominance: left, right, both

Location: left, right, bilateral, anterior, posterior, medial, lateral, deep, superficial

Quality: aching, burning, gnawing, stabbing, throbbing, sharp, dull, superficial, deep, occasional, frequent, constant, worsening, improving, no change

Severity: no pain, mild, moderate, severe, pain level ____/10, worst pain ____/10

Duration: date of onset: ____ days, ____ weeks, ____ months, ____ years, continuous since onset

Timing: cannot identify, acute, chronic, abrupt, gradual, morning, daytime, nighttime, recurrent, rare, occasional, intermittent episodes lasting _____

Context: cannot identify, fall, bending, lifting, twisting, sports injury, work injury, MVA, assault, overuse, a traumatic, laceration

Alleviating Factors: nothing helps, heat, ice, rest, elevation, exercise, stretching, limited weight bearing, PT/OT, chiropractic care, ESI, OTC medication, narcotics, NSAIDS, cortisone injection, vicosupplement injection, orthotics, previous surgery, brace, sling

Aggravating Factors: cannot identify, lifting, carrying, twisting, pushing/pulling, gripping, grasping, squeezing, throwing, ROM, weight bearing, exercise, previous surgery, computer use, changing clothes, getting out of bed, going from sit to stand, morning, daytime, nighttime, cold weather, damp weather

Associated Symptoms: weakness, numbness, tingling, swelling, redness, warmth, ecchymosis, catching/locking, popping/clicking, buckling, grinding, instability, radiating, drainage, fever, chills, weight loss, change in bowel/bladders habits

Previous Related Surgery: none, surgical procedure, date: _____

Prior Imaging: none, no recent studies, x-ray, MRI, CT Scan, bone scan, EMG

Previous Injections: none, did not help, helped a little, helped temporarily, helped significantly

Previous PT: none, did not help, helped a little, helped temporarily, helped significantly

Work Related: no, yes

Working: no, regular duty, modified duty

Review of Systems

(Please circle any that apply within the last week.)

Constitutional: fever, night sweats, weight gain (____ lbs.), weight loss (____ lbs.), exercise intolerance

Eyes: dry eyes, irritation, vision change

ENMT:

Ears: difficulty hearing, ear pain

Nose: frequent nosebleeds, nose/sinus problems

Mouth/Throat: sore throat, bleeding gums, snoring, dry mouth

Cardiovascular: chest pain on exertion, arm pain on exertion, shortness of breath when walking, shortness of breath when lying down, palpitations, known heart murmur, light-headed on standing

Respiratory: cough, wheezing, shortness of breath, coughing up blood, sleep apnea

Gastrointestinal: abdominal pain, vomiting, change in appetite, black or tarry stools, frequent diarrhea, vomiting blood

Genitourinary: urinary loss of control, difficulty urinating, increased urinary frequency, hematuria, incomplete emptying

Musculoskeletal: muscle aches, muscle weakness, joint pain, back pain, swelling in the extremities

Skin: abnormal mole, jaundice, rash, itching, dry skin, growths/lesions

Neurologic: loss of consciousness, weakness, numbness, seizures, dizziness, frequent or severe headaches, restless legs

Psychiatric: depression, sleep disturbances, restless sleep, feeling unsafe in relationship, alcohol abuse

Endocrine: fatigue, increased thirst, hair loss, increased hair growth, cold intolerance

Hematologic/Lymphatic: swollen glands, easy bruising, excessive bleeding

Allergic: runny nose, sinus pressure, itching, hives, frequent sneezing

The information on the medical form(s) I am completing today is accurate and to the best of my knowledge.

Signed _____ Date: _____

General Health Information

Name: _____ Date: _____

Past Surgical History: None to report

List Surgeries/Dates:

Any past hospitalizations OTHER THAN surgery (and dates): _____

Medications: None to report

List medication(s) you take and dosage: _____

Allergies/Adverse Reactions to Medications:

Are you allergic to any medications: Yes No

If yes, list Drug(s): _____ Reaction: _____ Est. Onset Date: _____

_____ Reaction: _____ Est. Onset Date: _____

Past Medical History: No to All If yes, check all that apply below:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Leg or Foot Ulcers
<input type="checkbox"/> Asthma	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Migraines
<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Other
<input type="checkbox"/> Depression	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Periperal Vascular Disease
<input type="checkbox"/> GERD/Reflux	<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> Gout	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Heart Attack (MI)	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Hernia	

Social History:

Smoking Status: Never a smoker Current smoker Former smoker

If you smoke, how much do you smoke per day? _____ # packs/day

Chewing tobacco: Yes No

Illicit drug use: Yes No Illicit drugs usage/years of use: _____

Alcohol intake: None Occasional Moderate Heavy

Work related injury: Yes No

Auto related injury: Yes No

If injured, is litigation ongoing: Yes No

Is blood transfusion acceptable in an emergency? Yes No

Hand Dominance: Right Left Bilateral

Are you currently employed? Yes No

Occupation: _____

Marital Status: Married Single Divorced Separated Widowed Domestic Partner

Do you live alone or with others? Alone With others

Exercise level: None Occasional Moderate Heavy

Sporting Activities: _____

Family History: None to report

Family Member(s):

Health problem:

Patient's Physician:

Name of Physician or Practice: _____

Address: _____ Phone: _____

Please add any additional information about your health.

The information on this medical history form is accurate and to the best of my knowledge.

Signed _____ **Date:** _____