

# Charlotte Orthopaedic Clinic

## New Patient History

<b>Patient Information</b>	<b>Date</b> _____
Name: _____	I Prefer to be called: _____
Last                      First                      MI                      Suffix (Jr., Sr., II)	
Address: _____	City: _____ State: _____ Zip _____
Phone (____) _____	Work Phone (____) _____ Cell Phone (____) _____
Northern Address: _____	City: _____ State: _____ Zip _____
Age: _____	Date of Birth: _____ Social Security Number: _____ E-mail: _____
Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
If Student, Name of School _____	City/State _____
Spouse or Parent/Guardian's Name _____	
Employer _____	
Whom may we thank for referring you? _____	
Family Doctor _____	Phone _____
Sports you participate in: _____	

I acknowledge that the information provided about my family and medical history is accurate and complete. If there are any changes to this information in the future, I will provide any such change at my next scheduled visit.

\_\_\_\_\_  
Patient or Parent/Guardian

\_\_\_\_\_  
Date

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN and TO RELEASE INFORMATION FOR INSURANCE CLAIMS:** I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible for payment of non-covered services. I hereby authorize the Physician to release any information acquired in the course of my treatment to process insurance claims.

\_\_\_\_\_  
Patient or Parent/Guardian

\_\_\_\_\_  
Date

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## Current Orthopaedic Problem (s)

What are you seeing the doctor for today: \_\_\_\_\_

Is this a second opinion  yes  no      Are you right or left handed:  right  left

What caused the pain/injury:  car accident       work accident       injury (other)       no injury

How did the injury occur? \_\_\_\_\_

When did the injury/accident occur? \_\_\_\_\_

Duration of symptoms:  days       weeks       months       years

Does the pain radiate to:  shoulder       elbow       fingers       groin       buttock       thigh       foot

The pain is getting:       better       worse       unchanged

The pain is:       constant       occasional

Pain level:       intolerable       tolerable

How would you rate the pain (0=no pain through 10=severe): \_\_\_\_\_

Does the pain prevent you from doing daily activities?       yes       no

What activities increase your symptoms? \_\_\_\_\_

Do you use a:       cane       walker       nothing

How many blocks can you walk before stopping? \_\_\_\_\_

Is the pain improved by:  Aspirin       Tylenol       Advil/Motrin/Ibuprofen       Other: \_\_\_\_\_

List of pain medication taken for this problem: \_\_\_\_\_

Did medication help?       yes       no

Have you had injections for this problem?       yes       no

What type of injection(s) \_\_\_\_\_

Did the injection help:       yes       no

Have you had physical therapy?       yes       no      If yes, when/ how long/ did it help? \_\_\_\_\_

Have you had surgery for this problem before?       yes       no      If yes, when and where \_\_\_\_\_

Was surgery successful?       yes       no      Complications: \_\_\_\_\_

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## Past Medical/Surgical History

Do you have a history of any of the following?

- |                      |                              |                             |                |                              |                             |
|----------------------|------------------------------|-----------------------------|----------------|------------------------------|-----------------------------|
| Fracture/broken bone | <input type="checkbox"/> yes | <input type="checkbox"/> no | Arthritis      | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Gout                 | <input type="checkbox"/> yes | <input type="checkbox"/> no | Bursitis       | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Tendonitis           | <input type="checkbox"/> yes | <input type="checkbox"/> no | Bone infection | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Neck pain            | <input type="checkbox"/> yes | <input type="checkbox"/> no | Back pain      | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Sciatica             | <input type="checkbox"/> yes | <input type="checkbox"/> no | Osteoporosis   | <input type="checkbox"/> yes | <input type="checkbox"/> no |

Do you have any medical conditions (treated or untreated)?

- |                       |                              |                             |                       |                              |                             |
|-----------------------|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|
| AIDS                  | <input type="checkbox"/> yes | <input type="checkbox"/> no | Anemia                | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Angina                | <input type="checkbox"/> yes | <input type="checkbox"/> no | Asthma                | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Emphysema/COPD        | <input type="checkbox"/> yes | <input type="checkbox"/> no | Bladder/Kidney        | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Bleeding disorder     | <input type="checkbox"/> yes | <input type="checkbox"/> no | Blood clots           | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Cancer                | <input type="checkbox"/> yes | <input type="checkbox"/> no | Diabetes              | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Depression/Anxiety    | <input type="checkbox"/> yes | <input type="checkbox"/> no | Mental disorder       | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Heart Attack          | <input type="checkbox"/> yes | <input type="checkbox"/> no | Heart disease         | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Atrial fibrillation   | <input type="checkbox"/> yes | <input type="checkbox"/> no | High Blood Pressure   | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Pacemaker             | <input type="checkbox"/> yes | <input type="checkbox"/> no | Parkinsons            | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Alzheimer's           | <input type="checkbox"/> yes | <input type="checkbox"/> no | Gastric Ulcer         | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Phlebitis             | <input type="checkbox"/> yes | <input type="checkbox"/> no | Prostate disease      | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Pulmonary emboli      | <input type="checkbox"/> yes | <input type="checkbox"/> no | Stroke                | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Thyroid disease       | <input type="checkbox"/> yes | <input type="checkbox"/> no | Liver disease         | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Sleep apnea (on CPAP) | <input type="checkbox"/> yes | <input type="checkbox"/> no | Peripheral neuropathy | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Glaucoma              | <input type="checkbox"/> yes | <input type="checkbox"/> no | Macular degeneration  | <input type="checkbox"/> yes | <input type="checkbox"/> no |
- Other illnesses not listed: \_\_\_\_\_

Have you had surgery before?

- |                       |                              |                             |                  |                              |                             |
|-----------------------|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|
| Tonsillectomy         | <input type="checkbox"/> yes | <input type="checkbox"/> no | Appendectomy     | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Hysterectomy          | <input type="checkbox"/> yes | <input type="checkbox"/> no | Prostate         | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Cardiac Stent         | <input type="checkbox"/> yes | <input type="checkbox"/> no | Cardiac Bypass   | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Vascular surgery      | <input type="checkbox"/> yes | <input type="checkbox"/> no | Laparoscopy      | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Shoulder/Rotator cuff | <input type="checkbox"/> yes | <input type="checkbox"/> no | Knee arthroscopy | <input type="checkbox"/> yes | <input type="checkbox"/> no |
- Other surgery not listed: \_\_\_\_\_

Date of last Dental Visit: \_\_\_\_\_ Dental Problems: \_\_\_\_\_

Medication Allergies:  Penicillin  Sulfa  Morphine  Codeine  Aspirin  
 Tylenol  Latex  Betadine  Other: \_\_\_\_\_

# Charlotte Orthopaedic Clinic

List of Current Medications:

<u>Name</u>	<u>Dosage</u>	<u>Quantity/Frequency</u>	<u>Name</u>	<u>Dosage</u>	<u>Quantity/Frequency</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Social History:

Present Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_

Do you smoke:  no  cigarettes  cigars How many per day/how long: \_\_\_\_\_

Do you drink alcohol:  no  socially  daily How many drinks per week: \_\_\_\_\_

Do you use recreational drugs?  no  yes If yes, what kind/how often: \_\_\_\_\_

Do you exercise:  yes  no How often/what type? \_\_\_\_\_

Family History: Father:  alive  deceased Age: \_\_\_\_ Cause of death: \_\_\_\_\_

Mother:  alive  deceased Age: \_\_\_\_ Cause of death: \_\_\_\_\_

Rheumatoid  Stroke  Cancer  Diabetes  Heart disease

Other: \_\_\_\_\_

**Do you now have (or have you had) any problems related to the following systems? **Circle** if yes...**

Constitutional: Fever	Chills	Headache	Other: _____
Eyes: Blurred vision	Double vision	Pain	Other: _____
Immunologic: Hay fever	Drug allergies	Seasonal allergies	Other: _____
Neurologic: Tremors	Dizzy spells	Seizures	Other: _____
Endocrine: Excessive thirst	Too hot/cold	Tired/sluggish	Other: _____
Gastrointestinal: Abdominal pain	Nausea/Vomiting	Heartburn	Other: _____
Cardiovascular: Chest Pain	Palpitations	High blood pressure	Other: _____
Integumentary: Skin rash	Boils	Persistent itching	Other: _____
Musculoskeletal: Swollen joints	Painful joints	Neck/Back pain	Other: _____
Ear/Nose/Throat: Ear infection	Sore throat	Sinus problem	Other: _____
Genitourinary: Painful urination	Frequent urge	Discharge	Other: _____
Respiratory: Wheezing	Frequent cough	Short of breath	Other: _____
Hematologic: Swollen glands	Blood clots	Bruising	Other: _____
Psychologic: Depression	Anxiety	Difficulty sleeping	Other: _____