

Patient Registration Form

(PLEASE PRINT IN BLACK INK, AND ANSWER ALL QUESTIONS)

CHART#

DATE

DOCTOR

IS THIS PROBLEM A PERSONAL INJURY OR WORK RELATED? IF YES, STOP AND INFORM RECEPTIONIST.

NAME _____ HOME PHONE _____
ADDRESS _____ APT# _____ WORK PHONE _____
CITY _____ EMPLOYER _____
STATE _____ ZIP _____ EMAIL _____ OCCUPATION _____
DATE OF BIRTH _____ AGE _____ OCCUPATION BEFORE RETIREMENT _____
 MALE FEMALE SOCIAL SECURITY # _____

SECOND ADDRESS
NAME _____ HOME PHONE _____
ADDRESS _____ APT# _____ WORK PHONE _____
CITY _____ STATE _____ ZIP _____

GUARDIAN OR EMERGENCY CONTACT:
NAME _____ STATE _____ ZIP _____
ADDRESS _____ PHONE # _____
CITY _____ RELATIONSHIP _____

PRIMARY INSURANCE:
MEDICARE PATIENTS: MEDICARE # _____ (IS MEDICARE PRIMARY INS? YES NO)
INSURANCE CO. _____ PHONE # _____
ADDRESS _____ POLICY / ID # _____
CITY _____ GROUP # _____
STATE _____ ZIP _____ POLICY OWNERS NAME _____
POLICY OWNERS SS# _____
POLICY OWNERS DATE OF BIRTH _____

SECONDARY INSURANCE: RELATION TO INSURED: SELF SPOUSE CHILD OTHER
INSURANCE CO. _____ POLICY OWNER'S NAME _____
ADDRESS _____ POLICY OWNER'S DATE OF BIRTH _____
CITY _____ POLICY OWNER'S SS # _____
STATE _____ PHONE # _____
ZIP _____ POLICY / ID # _____

CHECK ONE: HMO PPO DID YOU BRING A REFERRAL SLIP? YES NO
GETTING TO KNOW YOU: HOW DID YOU HEAR ABOUT THE FLORIDA KNEE AND ORTHOPEDIC CENTERS?

Attended Seminar Referred by our patients Referred by Physician
 Other
NAME AND ADDRESS OF YOUR PRIMARY CARE DOCTOR OR FAMILY DOCTOR: _____

PHONE _____ FAX _____
CARDIOLOGIST _____ PHONE _____ FAX _____

PLEASE CHECK ITEMS IF YOU HAVE EVER HAD:

Heart and circulation problems: None

- High blood pressure
- Low blood pressure
- Heart attack or coronary
- At what age _____
- Chest pain or angina lasting more than one minute
- Any cardiac arrhythmia or irregular heartbeat

Heart failure/Cardiomyopathy

- ⊗ Heart murmur /Valvular heart disease
- Which valve _____
- Being awakened from sleep by coughing or shortness of breath
- Blood clot in the lung
- Phlebitis(blood clot in the leg)
- Difficulty walking up two flights of steps (getting short of breath)
- Have you ever had cardiac tests
- Stress test When: _____ Where: _____
- Echocardiogram When: _____ Where: _____
- Catheterization/Coronary Stent/Angioplasty
- When: _____ Where: _____
- When: _____ Where: _____
- Open-heart surgery When: _____ Where: _____

Lung or breathing problems: None

- Shortness of breath or any difficulty breathing
- Any breathing problem which interfered with normal activity
- Do you use oxygen
- Do you bring up anything when you cough
- Asthma or wheezing
- Emphysema/COPD/Bronchitis
- Do you have sleep apnea
- An abnormal chest x-ray
- A cold at this time

Muscle or joint problems: None

- Unusual muscle weakness
- Back or neck problems
- Any limited movement in your neck or jaw
- Any treatment for sciatica

Neurological problems: None

- Stroke
- Epilepsy or seizures
- # per month: _____
- Frequent headaches or migraines
- Paralysis
- Dizziness or fainting
- An arm or leg that becomes numb or weak frequently
- Any treatment by a psychiatrist

Gastrointestinal problems: None

- Vomiting of blood
- Stomach pain or been treated for an ulcer
- Bloody or black stools
- Jaundice or hepatitis
- Cirrhosis or enlarged liver

Urinary tract or reproductive problems: None

- Painful burning during urination or frequent urination
- Kidney or bladder infection
- Prostate problems
- Kidney stone
- Blood in the urine
- Any kidney disease
- Could you be pregnant?
- Start date of last menstrual period
- Are you on dialysis

Metabolic and blood problems: None

- Diabetes
- ⊗ Do you take insulin
- How much _____
- Anemia
- Easy bleeding / poor blood clotting
- Frequent or large nosebleeds
- Sickle Cell disease
- Blood transfusions
- Do you take cortisone or steroids
- How much _____

Eye, ear, nose and throat problems: None

- Glaucoma or other eye problems
- Any serious mouth, throat or larynx (voice box) problem
- Any nose or jaw surgery
- When: _____ Where: _____
- Any false teeth, caps, bridges, loose or chipped teeth, crowns, braces
- Any contact lenses
- Any difficulty hearing

Other health questions . None

- Significant weight loss in the past 4 months without dieting?
- Loss of appetite?
- Cancer or other tumors or growths?
- Treatment for depression?
- Any history of skin changing color or of allergy after contact with jewelry or other metal?
- Are you under the treatment of any specialists?
- Are you feeling extremely anxious about pending surgery.

PAST MEDICAL HISTORY

Illnesses

Please list any other non-surgical illnesses you have had requiring hospitalization or repeated visits to your doctor and give dates:

PAST SURGICAL / ANESTHESIA HISTORY

Have you ever had any anesthesia or surgery? If so, list surgery and approximate dates:

Have you had any problems with prior anesthetics including nausea and vomiting? Yes No
If any problems, please describe:

- Ⓢ Waking up
- Ⓢ Putting in breathing tube
- Ⓢ Other

Have any of your blood relatives had any problems with anesthesia, including high fever? Yes No
Are you allergic to local anesthesia such as xylocaine? _____ Novocaine? _____
Have you had prolonged bleeding after tooth extraction or any bleeding problems? Yes No
Do you have problems with your neck or jaw? Ⓢ Yes Ⓢ No

Current medications

Are you taking any medications? Yes No

If yes, please list medication names and dose. Please include over the counter medicines and vitamin or herb supplements:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Allergies

Please check if allergic to any of these drugs:

- Penicillin Sulfa Codeine Iodine Novacaine Latex or Rubber

Describe your reaction to the medication: _____

Any other drug reactions or allergies to any other medicines? If so, please list and describe reaction:

Do you have asthma? Yes _____ No _____

SOCIAL AND FAMILY HISTORY

- Married. Single. Widowed. Divorced.

Did any of your blood relatives have a heart attack or coronary? At what age? _____

Did any of your blood relatives have rheumatoid arthritis or osteoarthritis? _____

Did any of your relatives have problems with anesthesia, including fever? _____

- Mother Living Deceased Cause of death _____ Age: _____
- Father Living Deceased Cause of death _____ Age: _____

Health care providers are required by some insurance companies to ask their patient if they have a living will. Yes No If yes, please provide us with a copy.

Do you live alone? Yes No If yes, how many? _____

Do you have children? Yes No

Exercise? Daily 2-3 x week Other _____

What type of exercise? _____

Are you on a special diet? Yes No

Describe _____

Recreational drug use? Yes No

Which type _____ When last used? _____

Currently smoking? No Yes, _____ packs per day, for _____ years

Quit smoking? This year + 1 year + 5 years + 10 years

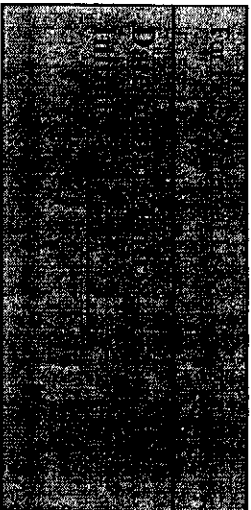
Previously smoked _____ packs per day _____ years

Drink alcohol? Yes No

Daily 1-2x/week 1-2x month Rarely

PATIENT _____ date _____

PHYSICIAN _____ date _____



HPI FORM - KNEE

NAME _____

CHART# _____

DATE _____

HISTORY OF PRESENT ILLNESS

Please check the answers that best describe your condition

Height _____ Weight _____ Age _____

When was the onset of your symptoms?

- Injury. How long ago? _____
- Sudden, without injury.
- Gradual onset – how many?
 _____ Weeks ago / _____ Months ago / _____ Years ago

What is the intensity of the pain?

- Mild.
- Moderate.
- Severe.

What activities aggravate the problem?

Duration of pain:

- Continuous. Intermittent.
- Chronic. Acute.

What type of treatment have you received?

- Over the counter medicine.
- Arthritis medicine.
- Cortisone shots.
- Herbal remedies.
- Surgery.
- Other _____

What is the quality of the pain?

- Improving.
- Worsening.
- Unchanged.

How much difficulty or disability does this

problem cause?

- It's a nuisance.
- It's threatening my independence.
- It's hindering my occupation or recreational activity.
- It poses no difficulty.

What kind of symptoms?

- Pain Swelling
- Stiffness Locking/Catching
- Other _____

Do any of the following apply?

- Previous injury to affected area.
- Back problems.
- Tendonitis.
- Recurrent sprains.
- Previous fracture.

Where is the location of the pain?

Knee:

- Right Left

- Other _____

Revised 8/05 a.s.

For ASKOC Internal Use

Date of Data Entry _____

Initials _____