CurPoint ORTHOPEDIC

Adult New Patient Registration

Patient Information (please print)

Last Name	First Name	Middle Initial	Date of Birth	Sex
			M M D D Y Y Y Y	❑ M ❑ F ❑ O

Phone (Home)	Phone (Mobile)	Preferred	Email

Occupation	Employer		Patient Marital Status

Emergency Contact	Emergency Contact Phone	Relationship

Primary Care Provider (PCP)	PCP Phone

Referring Provider	Referring Phone

Referring Pharmacy	Pharmacy Phone

Referring Address	City	State	Zip

Please list ALL ACTIVE treating physicians (e.g., primary care, internal medicine, cardiology, etc.)

Doctor's Name	Specialty

Doctor's Name	Specialty

Doctor's Name	Specialty

Doctor's Name	Specialty

Collection of the following information is encouraged by federal health agenies.
This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Decline to Answer

Race
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Pacific Islander
- ❑ Caucasian
- ❑ Other
- ❑ Decline to Answer

Preferred Language ❑ Decline to Answer

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the CurPoint Orthopedic Notice of Privacy Practices (NOPP). ❑ Received ❑ Received previously from CurPoint Orthopedic

I read and agree to all of the above (Financial Agreement, Notice of Privacy, Insurance Information).

Patient or Legal Guardian Name (Print)

Patient or Legal Guardian Name (Signature) Date

General Medical Questionnaire

Have you EVER had any of the following?

❑ Yes ❑ No Asthma/Breathing Problems
❑ Yes ❑ No Arthritis
❑ Yes ❑ No Bleeding / Clotting Disorder
❑ Yes ❑ No Blood Pressure Disorder
❑ Yes ❑ No Blood Transfusion
❑ Yes ❑ No Back / Stomach Problems
❑ Yes ❑ No Cancer
❑ Yes ❑ No Cholesterol Disorder
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Eye Disorder (i.e. Glaucoma, cataract)
❑ Yes ❑ No Gynecological Issues
❑ Yes ❑ No Heart Disease / Disorder
❑ Yes ❑ No Lung Disorder
❑ Yes ❑ No Liver Disease
❑ Yes ❑ No Neurological Disorder / Chronic Headaches
❑ Yes ❑ No Psychiatric Disorder / Illness
❑ Yes ❑ No Pulmonary Embolism / DVT
❑ Yes ❑ No Stroke
❑ Yes ❑ No Seizure or Epilepsy
❑ Yes ❑ No Thyroid Disorder
❑ Yes ❑ No Urinary / Kidney Disorder

Please list any other medical illnesses or problems and/or provide details for any of the above conditions.

Please list all past surgeries and hospitalizations and approximate dates.

Procedure / Hospitalization	Date

Please indicate any major conditions / illnesses that your immediate family members have had.

Relative	Condition	Living?	If deceased, at what age?
Mother		❑ Yes ❑ No	
Father		❑ Yes ❑ No	
Sibling		❑ Yes ❑ No	
Other:		❑ Yes ❑ No	

Do you currently smoke? ❑ Yes ❑ No **If no, previously?** ❑ Yes ❑ No **Years smoked:** _____ **Packs/day:** _____

Do you use other tobacco products? ❑ Yes ❑ No **Consume alcohol?** ❑ Yes ❑ No **If yes, drinks/week:** _____

If relevant: Any past pregnancies? ❑ Yes ❑ No **How many?** _____ **How many deliveries?** _____

Your Reasons for Today's Visit

Do you have any allergies to medications or other substance (pets, food, etc.)? ❑ Yes ❑ No

If yes, Please list allergies and reactions (e.g. rash, hives, throat swelling, anaphylaxis, etc.).

Allergy	Reaction	Allergy	Reaction

Please list ALL of your current medications, including over the counter medications, supplements and herbs.

Medication Name	Dosage	Medication Name	Dosage

Review of Symptoms

Please indicate ALL that you have experienced within the past 6–12 months

Constitutional

❑ Yes ❑ No Fever	❑ Yes ❑ No Sweats	❑ Yes ❑ No Sleep Disturbances
❑ Yes ❑ No Chills	❑ Yes ❑ No Weight Gain (___ Lbs)	❑ Yes ❑ No Other:
❑ Yes ❑ No Fatigue	❑ Yes ❑ No Weight Loss (___ Lbs)	
❑ Yes ❑ No Feeling Poorly	❑ Yes ❑ No Unexp. Wgt. Change	

Head, Eyes, Ears, Nose, and Throat

❑ Yes ❑ No Vision Problem	❑ Yes ❑ No Runny Nose	❑ Yes ❑ No Sore Throat
❑ Yes ❑ No Decreased Hearing	❑ Yes ❑ No Neck Stiffness	❑ Yes ❑ No Hoarseness
❑ Yes ❑ No Double Vision	❑ Yes ❑ No Nosebleed	❑ Yes ❑ No Ringing in Ears
❑ Yes ❑ No Light Sensitivity	❑ Yes ❑ No Congestion	❑ Yes ❑ No Vertigo
❑ Yes ❑ No Itchy Eyes	❑ Yes ❑ No Snoring	❑ Yes ❑ No Earache
❑ Yes ❑ No Red Eyes	❑ Yes ❑ No Dry Mouth	❑ Yes ❑ No Other:
❑ Yes ❑ No Eye Pain	❑ Yes ❑ No Flu-like Symptoms	

Cardiovascular

❑ Yes ❑ No Chest Pain	❑ Yes ❑ No Cold Extremities	❑ Yes ❑ No Irregular Heart Rhythm
❑ Yes ❑ No Palpitations	❑ Yes ❑ No Cold Hands or Feet	❑ Yes ❑ No Other:
❑ Yes ❑ No Leg Swelling	❑ Yes ❑ No Leg Pain w/ Walking	

Respiratory

❑ Yes ❑ No Chest Congestion	❑ Yes ❑ No Coughing up Sputum	❑ Yes ❑ No Wheezing
❑ Yes ❑ No Cough	❑ Yes ❑ No Rapid Breathing	❑ Yes ❑ No Other:
❑ Yes ❑ No Coughing up Blood	❑ Yes ❑ No Shortness of Breath	

Gastrointestinal

❑ Yes ❑ No Abdominal Pain	❑ Yes ❑ No Black/Tarry Stools	❑ Yes ❑ No Bowel Incontinence
❑ Yes ❑ No Blood in Stool	❑ Yes ❑ No Decreased Appetite	❑ Yes ❑ No Rectal Pain
❑ Yes ❑ No Vomiting	❑ Yes ❑ No Yellow Skin	❑ Yes ❑ No Heartburn
❑ Yes ❑ No Nausea	❑ Yes ❑ No Trouble Swallowing	❑ Yes ❑ No Painful Swallowing
❑ Yes ❑ No Constipation	❑ Yes ❑ No Change in Bowels	❑ Yes ❑ No Other:
❑ Yes ❑ No Diarrhea	❑ Yes ❑ No Vomiting Blood	

Neurological

❑ Yes ❑ No Headache	❑ Yes ❑ No Disorientation	❑ Yes ❑ No Seizures
❑ Yes ❑ No Dizziness	❑ Yes ❑ No Confusion	❑ Yes ❑ No Fainting (Syncope)
❑ Yes ❑ No Decreased Strength	❑ Yes ❑ No Burning Sensation	❑ Yes ❑ No Tremor
❑ Yes ❑ No Poor Coordination	❑ Yes ❑ No Numbness	❑ Yes ❑ No Memory Lapses/Loss
❑ Yes ❑ No Unsteady	❑ Yes ❑ No Tingling	❑ Yes ❑ No Other:

Musculoskeletal

❑ Yes ❑ No Joint Pain	❑ Yes ❑ No Joint Swelling	❑ Yes ❑ No Leg Swelling
❑ Yes ❑ No Neck Pain	❑ Yes ❑ No Muscle Cramps	❑ Yes ❑ No Other:
❑ Yes ❑ No Back Pain	❑ Yes ❑ No Muscle Pain	
❑ Yes ❑ No Limb Pain	❑ Yes ❑ No Muscle Weakness	

Genitourinary

❑ Yes ❑ No Frequent Urination	❑ Yes ❑ No Nocturia	❑ Yes ❑ No Vaginal Bleeding
❑ Yes ❑ No Incontinence	❑ Yes ❑ No Itching–Genital	❑ Yes ❑ No Irreg. Monthly Cycles
❑ Yes ❑ No Urinary Urgency	❑ Yes ❑ No Change in Libido	❑ Yes ❑ No Heavy Period Bleeding
❑ Yes ❑ No Painful Urination	❑ Yes ❑ No Painful Intercourse	❑ Yes ❑ No Other:
❑ Yes ❑ No Pelvic Pain	❑ Yes ❑ No Discharge–Vaginal	

Integumentary

❑ Yes ❑ No Rash	❑ Yes ❑ No Change in a Mole	❑ Yes ❑ No Skin Cancer
❑ Yes ❑ No Dry Skin	❑ Yes ❑ No Unusual Growth	❑ Yes ❑ No Other:
❑ Yes ❑ No Skin Wound	❑ Yes ❑ No Itching	

Psychiatric

❑ Yes ❑ No Depression	❑ Yes ❑ No Anxiety	❑ Yes ❑ No Other:

Hematologic / Lymphatic

❑ Yes ❑ No Easy Bruising	❑ Yes ❑ No Swollen Lymph Nodes	❑ Yes ❑ No Other:
❑ Yes ❑ No Easy Bleeding		

Endocrine

❑ Yes ❑ No Excessive Thirst	❑ Yes ❑ No Heat Intolerance	❑ Yes ❑ No Changes–Skin
❑ Yes ❑ No Cold Intolerance	❑ Yes ❑ No Changes–Hair	❑ Yes ❑ No Other:

OFFICE USE ONLY: Provider Signature_____ Date: _____