CAROLINA NeuroSurgery & Spine ASSOCIATES

PATIENT REGISTRATION

Physician_____

Date:_____ Int:_____

Account #_____

Name:_____ _____ _____

Last First MI Home Phone Work Phone

_____

Address City State Zip Code

Email Address_____ Do you live alone? ☐ Yes ☐ No Birthdate_____ Age_____

Sex: ☐ Male ☐ Female Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ White ☐ Unknown / Other

Occupation_____ Employer_____ Length of employment _____

Business Address_____

Name of Spouse or Parents_____

Referring Physician

_____

_____

_____

Phone _____

Primary Care Physician

_____

_____

_____

Phone _____

Which is your preferred hospital, if a procedure is required?_____

CURRENT CHIEF COMPLAINT:

When did your pain start?_____ Date of injury_____ How did symptoms start_____

_____

Pain began: ☐ Suddenly ☐ Gradually ☐ Chronic Related to: ☐ Job ☐ Accident ☐ Unsure ☐ Other:

_____

CURRENT MEDICAL PROBLEMS (Check all that apply):

☐ AIDS / HIV	☐ Diabetes – Type I or Type II	☐ Irregular Heartbeat	☐ Seizures
☐ Arthritis / Gout	☐ Depression	☐ Liver or Kidney Problems	☐ Stroke
☐ Asthma	☐ Emphysema / COPD	☐ Neuropathy	☐ Thyroid Disease
☐ Bleeding Condition	☐ Glaucoma	☐ Osteoporosis	☐ Ulcers or Reflux
☐ Blood clots / DVT	☐ Heart Disease or Heart Attack	☐ Pacemaker or heart valve	☐ Other _____
☐ Cancer (Type/Location)	☐ High Blood Pressure	☐ Pancreatitis	_____

MEDICAL HISTORY:

List Surgeries (include dates):

1. _____
2. _____
3. _____
4. _____

Medications you are currently taking:
(include dosage, supplements and over the counter drugs)

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

Other Illnesses requiring hospitalizations (include dates):

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

Medication Allergies ☐ Yes ☐ No. If yes, please list:

1. _____
2. _____
3. _____

Are you allergic to ADHESIVE TAPE? ☐ Yes ☐ No.

Are you allergic to LATEX? ☐ Yes ☐ No.

Are you allergic to CTContrast/ Kidney Dye/ Iodine ☐ Yes ☐ No.

Are you allergic to Gadolinium/ MRI Contrast? ☐ Yes ☐ No.

Pharmacy Name:_____ Phone:_____

May we have consent to access your medication history? ☐ Yes ☐ No.

REVIEW OF SYSTEMS: Please check YES or NO if you have had these in the last 6 months:

		Y	N		Y	N		Y	N
Constitutional:	Recurrent fevers			Fatigue			Weight loss / gain		
Skin:	Rash			Ulceration			Excessive dryness		
Hematologic:	Bruising			Easy bleeding			Swollen glands		
Endocrine:	Tremors			Hair loss			Generalized weakness		
Eyes:	Blurry			Dry eyes			Excess tearing		
ENT:	Ringing ears			Bloody noses			Trouble swallowing		
Cardio:	Chest pain			Racing heart			Leg swelling		
Respiratory:	Coughing			Congestion			Short of breath		
GI:	Tarry stools			Bloody stools			Abdominal pain		
Urinary:	Frequency			Blood urine			Burning		
Allergies / Immun:	Asthma			Hives			Hay fever		
Mus / Skeletal:	Muscle pain			Joint pain			Joint swelling		
Neurological:	Dizziness			Facial pain			Headaches		
Psychiatric:	Depression			Anxiety			Mood Swing		

Physician_____ Date:_____

Int:_____ Account # _____

IMMEDIATE FAMILY HISTORY:

Do you live with your spouse? ☐ Yes ☐ No Do you have children? ☐ Yes ☐ No. If so, list below

CHILDREN	AGE	HEALTH	PROBLEM
_____	_____	☐ Good	_____
_____	_____	☐ Good	_____
_____	_____	☐ Good	_____
_____	_____	☐ Good	_____
_____	_____	☐ Good	_____

Do any blood relatives have the following major health problems? If yes, Who?

☐ AIDS_____
☐ Aneurysm / Brain_____
☐ Asthma _____
☐ Bladder disease _____
☐ Blood vessel disease_____
☐ Cancer _____
Type:_____
☐ Degenerative disc disease _____

☐ Diabetes_____
☐ Epilepsy _____
☐ Heart Attack _____
☐ Heart problem _____
☐ High blood pressure _____
☐ Lung disease _____
Type:_____

☐ Migraine headaches_____
☐ Neurofibromatosis _____
☐ Polycystic kidney _____
☐ Psychological disorder _____
☐ Spina bifida _____
☐ Stroke _____
☐ Other _____

Are there any hereditary diseases in your family that you are aware of? ☐ Yes ☐ No. If yes, please list:_____

SOCIAL HISTORY:

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

Tobacco Use: ☐ None ☐ Smoke _____ pack per day _____Years smoked ☐ Chewing Tobacco / Snuff ☐ Cigars

Did you ever smoke? ☐ Yes ☐ No If yes, when did you quit?_____

Alcohol use: ☐ None ☐ Occasional / Social ☐ Daily

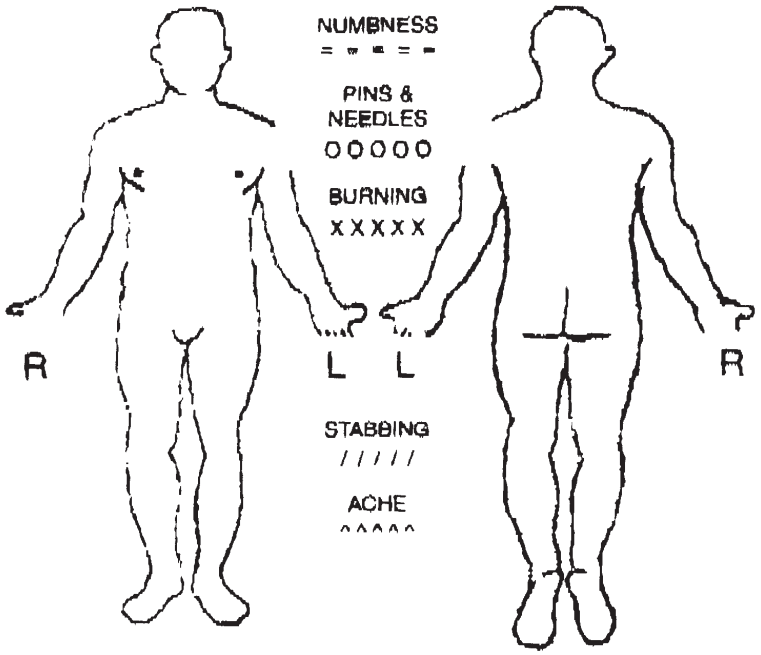
Are you pregnant? ☐ Yes ☐ No Is it possible that you could be pregnant?_____

Height_____ Weight_____ One year ago?_____ Maximum weight?_____ When?_____

Hand Preference: ☐ Right ☐ Left

FOR SPINE PATIENTS ONLY — WHERE IS YOUR PAIN NOW:

Mark all that apply:



	worse	better
Walking	☐	☐
Standing	☐	☐
Sitting	☐	☐
Lying down	☐	☐
Bending	☐	☐
Bowel Movement	☐	☐
Driving	☐	☐
Coughing / Sneezing	☐	☐
Rising from sitting	☐	☐
Home Remedy	☐	☐

VISUAL ANALOG SCALE

Please indicate on the scale below your level of pain with 10 being the worst. Use an "X" to indicate your most severe pain, and use an "O" to indicate your average amount of pain.

RATE YOUR PAIN

None ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Worst

Pain in arm(s) / leg(s) compared to neck / back: ☐ More than ☐ Same as ☐ Less than

Is there weakness of your arms / legs? ☐ Yes ☐ No

How long can you sit with no / minimal pain?_____ How long can you stand with no / minimal pain?_____

How far can you walk with no / minimal pain?_____

Have you had trouble controlling your bowels or bladder? ☐ Yes ☐ No If yes, is this a new problem? ☐ Yes ☐ No

In the past twelve months, have you had Physical Therapy, Chiropractic, Medications, Steroid Injections or Imaging studies for your pain?

☐ Yes ☐ No If yes, please check below and include last date of treatment.

	Dates of treatment		Dates of treatment		Dates of treatment		Dates of treatment
☐ None		☐ Discogram		☐ Non-narcotic meds		☐ Pain Management	
☐ MRI		☐ EMG / NCS		☐ Narcotic meds		☐ Holisitc Medicine	
☐ CT		☐ Bloodwork		☐ Physical Therapy		☐ Massage Therapy	
☐ Myelogram		☐ Epidural		☐ Chiropractic		☐ Accupuncture	
☐ X-Rays		☐ Facet Block		☐ Traction / Decompression		☐ Bracing	
☐ Bone Scan		☐ Steroid Injections		☐ Exercise Program		☐ Tens Unit	
	Describe/ List		Dates of treatment		Describe/ List		Dates of treatment
☐ Other _____				☐ Other _____			

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my physician or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date:_____ Patient's Signature _____

Date:_____ Physician's Signature _____