REZIN ORTHOPEDICS AND SPORTS MEDICINE
phone 815.942.4875 www.rezinortho.com fax 815.942.5046

PATIENT INFORMATION & REGISTRATION

TODAY'S DATE: ____/____/____

PATIENT INFORMATON

Last Name: _____
First Name: _____
Address: _____
City: _____ State_____ Zip_____
County: _____Country:_____
Home Phone: (_____) _____-_____
Cell Phone: (_____) _____-_____
Email Address: _____

Date of Birth: _____ /_____ / _____ Age_____
Social Security Number: _____-_____-_____

Gender: ☐ Female ☐ Male

Race: ☐ African-American/Black ☐ Caucasian/White
☐ American Indian-Alaska Native ☐ Multi-Racial
☐ Native Hawaiian/Pac Islander ☐ Other

Ethnicity: ☐ Hispanic, Latino, or Spanish Origin
☐ Not Hispanic, Latino, or Spanish Origin

Patient Employer: _____
Address: _____
City: _____ State_____ Zip_____
Employer Phone: (_____) _____-_____

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

Spouse Name: _____
Spouse Employer: _____
Spouse Work Phone: (_____) _____-_____

Emergency Contact: _____
Relationship to Patient: _____
Emergency Contact Phone: (_____) _____-_____

Currently residing in a Nursing Home: ☐Yes ☐No
If yes, Name of Nursing Home: _____

IF PATIENT IS A MINOR OR STUDENT, PLEASE COMPLETE THIS SECTION

Father's Name: _____
Address: _____
Phone: (_____) _____-_____ ☐ Home ☐ Work ☐ Cell
Date of Birth: _____ /_____ / _____
Social Security Number: _____-_____-_____
Employer: _____

Mother's Name: _____
Address: _____
Phone: (_____) _____-_____ ☐ Home ☐ Work ☐ Cell
Date of Birth: _____ /_____ / _____
Social Security Number: _____-_____-_____
Employer: _____

INSURANCE INFORMATION

Primary Insurance: _____
Cardholder: _____
ID No. _____ Group No. _____
Relationship to Patient: _____
Date of Birth: _____ /_____ / _____
Social Security Number: _____-_____-_____
Employer: _____

Secondary Insurance: _____
Cardholder: _____
ID No. _____ Group No. _____
Relationship to Patient: _____
Date of Birth: _____ /_____ / _____
Social Security Number: _____-_____-_____
Employer: _____

**** <u>IF THIS IS A WORK RELATED INJURY, PLEASE FILL OUT THE WORK COMP INFORMATION ON THE NEXT PAGE</u>****

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MEDICAL RELEASE INFORMATION

Who may we release medical information to?

1. _____ Phone: (_____) _____-_____ Relationship: _____
2. _____ Phone: (_____) _____-_____ Relationship: _____

May we leave medical information on the answering machine or voice mail of the phone number(s) you have listed?: ☐ Yes ☐ No

REFERRING SECTION

Referred By:

☐ Self
☐ Family Member
☐ Doctor _____
☐ Attorney _____
☐ Other _____

Referring Physician or Attorney
Address: _____
City: _____ State_____ Zip_____
Phone: (_____) _____-_____

PRIMARY CARE PHYSICIAN

Name: _____
Address: _____
City: _____ State_____ Zip_____
Phone: (_____) _____-_____
Fax: (____) ____-_____

WORK COMP SECTION

Have you reported this injury to your Employer? ☐ Yes ☐ No
Have you involved an attorney? ☐ Yes ☐ No

Work Comp Insurance Company: _____ Claim#: _____
Adjuster: _____ Phone: (_____) _____-_____
Contact Person for Employer: _____ Phone: (_____) _____-_____
How did your injury occur?: _____
_____

I HAVE REVIEWED THIS INFORMATION.

Patient Signature: _____ Date: _____/_____/_____

FOR OFFICE USE ONLY

Staff Initials_____

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CURRENT MEDICATIONS **I AM NOT CURRENTLY TAKING ANY MEDICATIONS** ☐

List any medication you are currently taking including items such as aspirin, vitamins, laxatives, calcium supplements, over-the-counter medications, etc. If you need additional space, please write on the back of this page. Thank you.

Name of Medication	Dosage	Frequency	How long have you taken this medication	This medication has helped: A Lot	Some	None
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
Pharmacy Name:		Location:		Phone: (____) ____-_____		

ALLERGIES (Please list your allergies) **NO KNOWN ALLERGIES** ☐

Name of Food, Drug or Item	Reaction	Name of Food, Drug or Item	Reaction

TODAY'S VISIT

Describe the reason for your visit today: _____

_____

Have you seen a physician for today's problem? ☐ Yes ☐ No

Who?_____

What was the diagnosis of the other physician? _____

_____

What tests/procedures did the other physician order?

☐ DEXA scan ☐ X-ray ☐ Bone scan ☐ MRI ☐ Other

Date of test/procedure: _____/_____/_____

Results of test/procedures: _____

Describe any previous treatments for today's problem: _____

Is this problem…

The result of an accident? ☐ Yes ☐ No

Auto related? ☐ Yes ☐ No

Work related? ☐ Yes ☐ No

Have you involved an attorney? ☐ Yes ☐ No

Date of injury: _____/_____/_____

Date symptoms began: _____/_____/_____

HISTORY OF PRESENT ILLNESS

What are you being seen for today? _____

What are your symptoms? _____

When did you your symptoms first appear? _____/_____/_____ If accident, when did it occur? _____/_____/_____

Where did symptoms occur or accident take place? _____

How did the symptoms manifest or occur? _____

SOCIAL HISTORY

Relationship	**Employment**	**Pregnancy**	**Handed**	**Exercise**	**Tobacco Use**	**Alcohol Use**
☐ Single	☐ Employed	☐ Pregnant	☐ Left	☐ Never	☐ Cigarettes	☐ Beer
☐ Married	☐ Unemployed	☐ Not Pregnant	☐ Right	☐ Rarely	☐ Cigars	☐ Wine
☐ Separated	☐ Retired			☐ Monthly	☐ Chew	☐ Mixed Drinks
☐ Divorced	☐ Disabled			☐ Weekly	☐ Quit	☐ No alcoholic drinks
☐ Widowed	☐ Student			☐ Daily	☐ Never	

I drink_____ alcoholic drinks per ☐ Day ☐ Week ☐ Month

I smoke _____ packs per day ☐ 1/4 ☐ 1/2 ☐ 1 ☐ 2+

I have smoked for _____ years

I have a history of substance abuse ☐ Yes ☐ No If yes, type:

Occupation: Hobbies/recreations:

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PATIENT NAME: _____ **Date of Birth** _____/_____/_____

PATIENT'S PAST MEDICAL HISTORY *Please check all that apply* **NO PAST MEDICAL HISTORY** ☐

- ☐ Anemia
- ☐ Ankle Swelling
- ☐ Anxiety/Panic Attacks
- ☐ Anesthesia Complications
  - ☐ *Malignant Hyperthermia*
- ☐ Arrhythmia
- ☐ Arthritis/Osteoarthritis
- ☐ Asthma/Lung Disease
- ☐ Bleeding Tendency
- ☐ Blood Clots/DVT
- ☐ Blood Thinners _____
- ☐ Bone/Joint Infection
- ☐ Bruise Easily
- ☐ Bunions
- ☐ Cancer _____
  - ☐ *Chemo* ☐ *Radiation*
- ☐ Cardiac Problems
- ☐ Carpal Tunnel, Neuropathy
- ☐ Chest Pain, Angina
- ☐ Circulatory Problems
- ☐ Cirrhosis, Jaundice
- ☐ Claustrophobia
- ☐ Deafness or hearing trouble
- ☐ Depression
- ☐ Diabetes ☐ 1 ☐ 2
- ☐ Diverticulitis
- ☐ Emphysema or COPD
- ☐ Fainting/loss of consciousness
- ☐ Fatigue/Weakness
- ☐ Gall Stones
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack/MI
- ☐ Heart Condition (congenital)
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ HIV
- ☐ Hypertension (High BP)
- ☐ Irritable Bowel Syndrome
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Kidney Disease
- ☐ Kidney Failure
  - ☐ *Dialysis* ☐ *No Dialysis*
- ☐ Liver Disease
- ☐ Lumbar Disk Disease
- ☐ Lyme Disease
- ☐ Morning Stiffness
- ☐ Multiple Sclerosis
- ☐ Muscle Spasms
- ☐ Muscle Tenderness
- ☐ Muscle Weakness
- ☐ Myasthenia Gravis
- ☐ Numb/Tingling hands/feet
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Parkinson's Disease
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Poly/Fibromyalgia
- ☐ Renal Failure
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Skin Problems/Disorders
- ☐ Sleep Apnea
- ☐ Spinal Stenosis
- ☐ Stroke/TIA
- ☐ TB (Tuberculosis)
- ☐ Thyroid ☐ High ☐ Low
- ☐ TMJ (Jaw locks or pops)
- ☐ Ulcers/Reflux/GERD
- ☐ Vascular/Circulatory
- ☐ Varicose Veins
- ☐ Vertigo
- ☐ Other _____

PAST SURGICAL HISTORY *Please check all that apply* **NO PRIOR SURGERIES** ☐ **PROBLEMS WITH ANESTHESIA?** ☐ **Yes** ☐ **No**

Orthopedic Surgery

- ☐ ACL Reconstruction
- ☐ Arthroscopy (Circle Below)
- ☐ Ankle ☐ Left ☐ Right
- ☐ Elbow ☐ Left ☐ Right
- ☐ Hip ☐ Left ☐ Right
- ☐ Knee ☐ Left ☐ Right
- ☐ Shoulder ☐ Left ☐ Right
- ☐ Wrist ☐ Left ☐ Right
- ☐ Back Surgery
- ☐ Previous Fractures? _____
- ☐ Ankle Replacemt. ☐ Left ☐ Right
- ☐ Carpal Tunnel Rel. ☐ Left ☐ Right
- ☐ Hip Replacement ☐ Left ☐ Right
- ☐ Knee Replacemt. ☐ Left ☐ Right
- ☐ Shoulder Replace. ☐ Left ☐ Right
- ☐ Other _____
  _____
  _____

General Surgery

Describe other surgical procedures _____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY *Please check all that apply and indicate who was diagnosed* **NO PAST MEDICAL HISTORY** ☐

Disorder	Who			
☐ Alcohol Liver Disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Bleeding Disorder	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Colon Polyps	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Diabetes 1 ☐ 2 ☐	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ GERD	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Heart Disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Stroke	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Anesthetic Complications	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Cancer	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Type: _____	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Type: _____	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Type: _____	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Type: _____	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Type: _____	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Rheumatoid Arthritis	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
☐ Osteoarthritis	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent

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PATIENT REVIEW OF SYSTEMS *Please check all the symptoms you are currently experiencing*

CONSTITUTIONAL
- ☐ Fever
- ☐ Fatigue/Weakness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ OTHER: _____

EYES
- ☐ Blurred Vision
- ☐ Failing Vision
- ☐ Vision Loss
- ☐ Eye Pain
- ☐ OTHER: _____

ENT
- ☐ Ear Discharge
- ☐ Hearing Loss
- ☐ Nosebleeds
- ☐ OTHER: _____

CHEST
- ☐ Swelling
- ☐ Masses
- ☐ Pain
- ☐ OTHER: _____

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Heart Defects
- ☐ Palpitations
- ☐ Murmurs
- ☐ Other_____

RESPIRATORY
- ☐ Difficulty Breathing
- ☐ Chronic Coughing
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ History of TB
- ☐ TB Exposure
- ☐ OTHER: _____

GASTROINTESTINAL
- ☐ Appetite Loss
- ☐ Nausea (persistent)
- ☐ Vomiting
- ☐ Chronic Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ GI Bleed
- ☐ Ulcers/Reflux/GERD
- ☐ Blood in Stool
- ☐ Hepatitis
- ☐ OTHER: _____

GENITOURINARY
- ☐ Difficult Urination
- ☐ Frequent Urination (PM)
- ☐ Leakage of Urine
- ☐ Passing Stones
- ☐ Pregnancy
- ☐ Other _____

MUSCULOSKELETAL
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Stiffness
- ☐ Arthritis
- ☐ Ankle Swelling
- ☐ Disturbance in walking
- ☐ Tingling Sensation
- ☐ OTHER: _____

NEUROLOGICAL
- ☐ Memory Loss
- ☐ Seizures
- ☐ Weakness
- ☐ Dizzy Spells
- ☐ Severe Headaches
- ☐ Difficulty Walking
- ☐ Stroke/TIA
- ☐ OTHER: _____

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Memory Loss
- ☐ OTHER: _____

ENDOCRINE
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Thyroid Trouble
- ☐ OTHER: _____

VASCULAR/IMMUNO
- ☐ Abnormal Bruising
- ☐ Bleeding Disorders
- ☐ HIV
- ☐ OTHER: _____

ALLERGY
- ☐ Latex Allergy
- ☐ Drug Allergies
- ☐ Recurrent Infections
- ☐ Adhesive bandages
- ☐ Anesthesia Complications
- ☐ Nickel (metal)
- ☐ Stainless Steel
- ☐ OTHER: _____

SKIN
- ☐ Skin Rash
- ☐ Itching
- ☐ Suspicious Lesions
- ☐ OTHER: _____

Physician Initials: _____