Dignity Health
Mercy Hospitals

Patient Registration

Name: (LAST) (FIRST) (MIDDLE)

Today's Date:

Date of Birth: Age: Gender: ☐Male ☐Female

☐Right-handed ☐Left-handed

Were you referred to our office by friend, relative, current treating physician or other? ☐Yes ☐No

Were you treated as an emergency by one of our doctors prior to this visit? ☐Yes ☐No

Doctors name:

Primary Care Physician (PCP) Name:

CHIEF COMPLAINT: (REASON FOR VISIT)

Date of injury: Where did injury occur:

Is this job related? ☐Yes ☐No If yes, describe how it occurred:

Prior industrial injuries? ☐Yes ☐No If yes, describe how it occurred:

Prior injury area of complaint? ☐Yes ☐No If yes, describe injury:

Job Title: Length of employment in this capacity:

HISTORY OF PRESENT ILLNESS / INJURY:
(PLEASE **CHECK** ANY OF THE FOLLOWING THAT BEST DESCRIBE YOUR PROBLEM)

Area(s) of Pain:
☐ Right ☐ Left ☐ Bilateral ☐ Hand ☐ Wrist ☐ Elbow
☐ Shoulder ☐ Hip ☐Knee ☐ Back ☐ Neck ☐ Other

Severity of Pain:
☐0-1 No pain ☐ 2-3 Mild pain ☐ 4-5 Discomforting ☐6-7 Distressing ☐8-9 Intense ☐ 10 Unbearable

Quality of Pain:
☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Aching

Duration of Pain:
☐ Intermittent ☐ Constant ☐ Minutes

Timing of Pain (makes pain worse):
☐ With exercise ☐ Activity ☐ Nightly ☐ At rest ☐ Sitting ☐ Walking

Modifying factors (makes pain better):
☐Rest ☐ Heat ☐ Cold ☐ Elevation ☐ Standing ☐ Sitting ☐ Walking

Context of Pain:
☐ Worsening ☐ Recurrent ☐ Improving

Associated signs:
☐ Bruising ☐ Numbness ☐ Tingling ☐ Buckling ☐ Locking ☐ Weakness

PRIOR TREATMENTS FOR THIS CONDITION: (PLEASE **CHECK** ALL THAT APPLY)

☐None

☐Nonsteroidal anti-inflammatory drugs (Ibuprofen, Aleve, Celebrex, etc)

☐Narcotic pain medications (Vicodin, Norco, Percocet, Tramadol, Oxycontin, Fentanyl patch, etc.)

☐Other medications (Neurontin, Cymbalta, Amitriptyline, Steroids, Muscle Relaxants, etc): which ones?

☐Physical Therapy

☐Injections (hand, wrist, shoulder, knee, etc): which ones?

☐Chiropractic: name of doctor:

☐Pain management specialist: name of doctor

☐Other Treatments (acupuncture, homeopathic, herbal, other):

☐Surgery (include specific details in past surgical history, page 4)

Spine Patients **ONLY:**

☐Spinal injections (epidural, facet joint, other): type of injection

Did pain get better after injection? ☐Yes ☐No

How long did pain relief from injection last?

☐Spinal Surgery: List type of surgery, when it was done and name of surgeon:

SOCIAL HISTORY:

Drink alcohol?	☐ Yes ☐ No ☐ Formerly	If "yes", how often?
Do you smoke?	☐ Yes ☐ No ☐ Formerly	If "yes", how often?
Do you exercise?	☐ Yes ☐ No	
Do you use illegal drugs?	☐ Yes ☐ No	If "yes", which one(s)
Are you adopted?	☐ Yes ☐ No	

FAMILY HISTORY: Please place a check mark if there is a family history of the following:

☐Alcoholism	☐Cancer-Colon	☐Heart Disease	☐Spine Problems
☐Alzheimer's	☐Cancer-Other	☐High Blood Pressure	
☐Arthritis	☐Cancer-Prostate	☐High Cholesterol	
☐Bleeding Disorder	☐Diabetes	☐Kidney Problems	
☐Cancer-Breast	☐Gout	☐Malignant Hyperthermia	

☐Other family history of

☐No family history

ILLNESSES: Please place a checkmark if you have or have had any of the following illnesses:

☐ Acid Reflux
☐ Alcoholism
☐ Alzheimer's
☐ Anemia
☐ Aneurysm
☐ Angina
☐ Asthma
☐ Bleeding Disorder
☐ Blood Clot
☐ Broken Bones
☐ Cancer
☐ Cerebral Palsy
☐ Currently Pregnant
☐ Degenerative Disc
☐ Depression
☐ Diabetes
☐ Epstein Barr
☐ Fibromyalgia
☐ Glaucoma
☐ Gout
☐ Heart Disease
☐ Heart Murmur
☐ Heart Pacemaker
☐ Hepatitis
☐ Herniated Disc
☐ Hiatal Hernia
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ Irregular Heart Beat
☐ Keloids
☐ Kidney Problems
☐ Liver
☐ Lupus
☐ Migraine
☐ Mitral Valve Prolapse
☐ Myelopathy
☐ Myocardial Infarction
☐ Nervous Condition
☐ Osteoarthritis
☐ Osteoporosis
☐ Parkinson's
☐ Peptic Ulcer
☐ Peripheral Vascular Disease
☐ Phlebitis
☐ Rheumatoid Arthritis
☐ Scoliosis
☐ Seizures
☐ Skin Problems
☐ Spinal Stenosis
☐ Spondylolisthesis
☐ Stomach Ulcer
☐ Stroke
☐ Thyroid Problem
☐ Tuberculosis
☐ Valley Fever
☐ Other Illnesses
☐ No illnesses

ALLERGIES:

☐ No known allergies ☐ Latex sensitivity/allergy

Substance	Effect

MEDICATIONS:

Prescription, over-the-counter, vitamins and herbals

OPERATIONS: Please place a checkmark if you have had procedures on any body part listed. Please include the specific procedure, right/left or bilateral and approximate date, in the space provided.

☐ Abdominal
☐ Amputation
☐ Ankle
☐ Appendectomy
☐ Arm
☐ Biopsy
☐ Bladder
☐ Bowel
☐ Breast
☐ Cardiac (Heart)
☐ Carotid
☐ Carpal Tunnel
☐ Cataracts
☐ Dental
☐ Dermatology
☐ Discectomy
☐ Elbow
☐ Feet
☐ Finger
☐ Fracture
☐ Gallbladder
☐ Hand
☐ Head/eyes/ears/nose/throat
☐ Heart Stent
☐ Hernia
☐ Hip
☐ Hip Replacement
☐ Kidney
☐ Knee
☐ Knee Arthroscopy
☐ Knee Replacement
☐ Laminectomy
☐ Liver
☐ Lungs
☐ OB/Gyn (Female)
☐ Pacemaker
☐ Parathyroidectomy
☐ Plastic Surgery
☐ Prostatectomy
☐ Rectal
☐ Shoulder
☐ Shoulder Replacement
☐ Spinal Fusion
☐ Spleen Removed
☐ Stomach
☐ Testicle
☐ Thyroid
☐ Trachea
☐ Ulcers
☐ Vasectomy
☐ Vertebral Disc Replacement
☐ Wrist
☐ Other Operations
☐ No past surgical history

REVIEW OF SYSTEMS: Please indicate whether or not you have any of the following conditions or symptoms

Cardiovascular

No Yes

☐ ☐ Chest pain
☐ ☐ Elevated Blood Pressure
☐ ☐ Irregular Heartbeat/Palpitations
☐ ☐ Leg Edema
☐ ☐ Syncope

Constitutional

No Yes

☐ ☐ Chills
☐ ☐ Decreased Appetite
☐ ☐ Fatigue
☐ ☐ Fever
☐ ☐ Night Sweats
☐ ☐ Weight loss

Metabolic/Endocrine

No Yes

☐ ☐ Adrenal Insufficiency
☐ ☐ Diabetes (Insulin Dependent)
☐ ☐ Diabetes (Non-insulin Dependent)
☐ ☐ Osteoporosis
☐ ☐ Thyroid Disorder

GI – Gastrointestinal

No Yes

☐ ☐ Black Tarry Stools
☐ ☐ Bowel Incontinence
☐ ☐ Constipation
☐ ☐ Diarrhea
☐ ☐ Jaundice
☐ ☐ Nausea
☐ ☐ Rectal Bleeding
☐ ☐ Vomiting

GU – Genitourinary

No Yes

☐ ☐ Difficulty Urinating
☐ ☐ Frequently Urinating
☐ ☐ Kidney Stones
☐ ☐ Sexual Dysfunction
☐ ☐ Urinary Incontinence

Head/Eyes/Ears/Nose/Throat

No Yes

☐ ☐ Blurry Vision
☐ ☐ Difficulty swallowing
☐ ☐ Double vision
☐ ☐ Hearing Loss
☐ ☐ Hoarse Voice
☐ ☐ Nose Bleeds
☐ ☐ Ringing in ears
☐ ☐ Wears glasses/contacts

Hematologic/Lymphatic

No Yes

☐ ☐ Anemia
☐ ☐ Bleeding
☐ ☐ Bruising
☐ ☐ Node swelling
☐ ☐ Slow to heal after cuts

Skin

No Yes

☐ ☐ Chronic wounds
☐ ☐ Rash
☐ ☐ Skin Lesions
☐ ☐ Ulcerations

Musculoskeletal

No Yes

☐ ☐ Back pain
☐ ☐ Difficulty walking
☐ ☐ Fibromyalgia
☐ ☐ Joint pain
☐ ☐ Muscle Cramping
☐ ☐ Muscle weakness
☐ ☐ Neck pain

Neurologic

No Yes

☐ ☐ Dizziness
☐ ☐ Headaches
☐ ☐ Numbness
☐ ☐ Seizures
☐ ☐ Stroke
☐ ☐ Tingling

Psychiatric

No Yes

☐ ☐ Anxiety
☐ ☐ Confusion
☐ ☐ Depression
☐ ☐ Insomnia
☐ ☐ Memory Loss
☐ ☐ Suicidal Ideation

Respiratory

No Yes

☐ ☐ Cough
☐ ☐ Hemoptysis
☐ ☐ Orthopnea
☐ ☐ Shortness of Breath
☐ ☐ Wheezing