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