THE CENTER
ORTHOPEDIC & NEUROSURGICAL CARE & RESEARCH

MRN # _____ Provider#: _____
Patient Portal: ☐ Information provided ☐ Declined
Clinical Summary: ☐ Print ☐ Portal ☐ Declined

Appointment Date: ___/___/___ Name: _____

Date of Birth: ___/___/___ Height: _____ Weight: _____ Dominant Hand: R / L / Ambidextrous

Family Doctor: _____ Referring Doctor: _____

MEDICAL HISTORY – Check any that apply

☐ Adverse Reaction to Anesthesia	☐ Blood Clots	☐ Depression	☐ Heart Attack	☐ Jaundice	☐ Thyroid
☐ Anemia	☐ Bronchitis	☐ Diabetes	☐ Heart Failure	☐ Pacemaker	☐ Tuberculosis
☐ Anxiety	☐ Cancer (type? _____)	☐ Dialysis	☐ Hepatitis	☐ Pneumonia	☐ Ulcers
☐ Arthritis	☐ Chest Pain	☐ Easy Bleeding	☐ High Blood Pressure	☐ Rheumatic Fever	☐ **Other** _____
☐ Asthma / Emphysema	☐ COPD	☐ Gout	☐ Home Oxygen	☐ Seizures/ Epilepsy	☐ **Other** _____
☐ Back Injury	☐ CPAP	☐ Headaches/ Migraines	☐ Irregular Heart Rate	☐ Strokes	☐ **Other** _____

SURGICAL HISTORY/HOSPITALIZATIONS

_____ / year: _____ _____ / year: _____ _____ / year: _____
_____ / year: _____ _____ / year: _____ _____ / year: _____
_____ / year: _____ _____ / year: _____ _____ / year: _____

FAMILY MEDICAL HISTORY - Among Parents, Siblings and Children

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP
☐ Cancer (specify type)		☐ Joint Problems	
☐ Diabetes		☐ Kidney Trouble	
☐ Seizures		☐ Thyroid	
☐ Headaches		☐ Other_____	
☐ Heart Trouble		☐ Other_____	

FAMILY/SUPPORT SYSTEM

☐ Married ☐ Single
☐ Widowed ☐ Separated
☐ Divorced
☐ Committed Significant Other

Do you have children? **YES** ☐ **NO** ☐
Do you live alone? **YES** ☐ **NO** ☐
Have help at home? **YES** ☐ **NO** ☐
Occupation:_____
Hobbies: _____
_____

HABITS (Check any that apply)

☐ Never a Smoker
☐ Former Smoker: Year quit? _____
☐ Current Some Day Smoker: How much? _____
☐ Current Every Day Smoker: How much? _____
☐ Chewing Nicotine-Containing Substances:
If yes, what & how much? _____
☐ Alcohol: How much? _____
☐ Caffeine: How much? _____
☐ Recreational Drugs _____

ALLERGIES (TO MEDICATIONS & NON-MEDICATIONS)

_____/Reaction_____
_____/Reaction_____
_____/Reaction_____
_____/Reaction_____
_____/Reaction_____
_____/Reaction_____

Allergy to Latex? ☐ /Reaction_____
Allergy to Iodine? ☐/Reaction_____

LIST CURRENT MEDICATIONS, MEDICINAL MARIJUANA, VITAMINS, & HERBAL SUPPLEMENTS (Include strength & dosage for each)

Preferred Language: _____ Race: ☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Unknown
☐ White
☐ Declined
☐ Other _____

Ethnicity: ☐ Hispanic or Latino
☐ Non-Hispanic or Non-Latino
☐ Unknown
☐ Declined

*Preferred Pharmacy: _____ *Preferred Pharmacy Location: _____

IF ADDITIONAL SPACE IS NEEDED FOR RESPONSES, PLEASE USE OTHER SIDE OF FORM