Spine & Orthopedic Center of New Jersey

Patient Medical History

Name: ______________________________ Date: ______________

Date of Birth: ______________ Age: ______ Height: ________ Weight: ________

Primary Care Physician: ______________ Date of Injury/Onset of Complaint: ______________

____

Have you seen any other Physicians for this problem? ___ Yes ___ No If yes, please give Physicians name and information: ______________________________

Do you have any allergies? ___ Yes ___ No If yes, please list: ______________________________

Do you have any drug allergies? ___ Yes ___ No If yes, please list: ______________________________

Please list any medications you are currently taking: ______________________________

Please check if you have or had any of the following:

________ Heart Disease ________ Lung Disease ________ Stomach Problems ________ Ulcer

________ Urinary Infections ________ Diabetes ________ Arthritis ________ Cancer

________ Numbness/Tingling ________ High Blood Pressure ________ Bleeding Tendencies ________ HIV

________ Asthma ________ Scoliosis ________ History of MRSA_____ Hepatitis: __A __B __C

List any surgeries: ______________________________

If so, do you have any hardware or implants? ______________________________

Work Status: ____ Full Time ____ Part Time ____ Retired _____ Temp Disabled ______ Perm Disabled _____ Student

Employed by: ______________________________

Have you missed work due to this current problem? _______ Yes _______ No

Marital Status: ______ Single ______ Married ______ Divorced ______ Separated ______ Widow(er)

Have you smoked 100 cigarettes in your lifetime? _____ Yes _____ No

Current Smoking Status: _____ Everyday _____ Some days _____ Former Smoker _____ Never Smoked

Alcohol consumption: _____ Daily _____ Weekly _____ Monthly _____ Yearly _____ None

FAMILY HISTORY	Alive/Deceased	Age	Health Status/Cause of Death
Father	___________	__	______________________
Mother	___________	__	______________________
Sibling's	___________	__	______________________

Patient Signature: ______________________________ Dated: ____________

Reviewed by: ______________________________ Dated: ____________

REV. 3/13