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 ☐

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

Clear Form Submit Form