



CEDARS-SINAI MEDICAL CENTER.

ORTHOPAEDIC INFORMATION FORM

1.) Primary language _____ Languages _____

2.) What is the reason for your visit? _____

3.) Medical History: (List any medical conditions)

4.) Medications: (Specify dose and frequency)

5.) Any drug allergies? (List reaction(s) to drug(s))

6.) History of surgery (Specify type and date)

7.) Have you smoked in the last 12 months? Please circle YES or NO.

8.) Are you having pain? Please circle YES or NO.

9.) Level of pain presently, on a scale of 1-10 with 10 being the highest.

10.) Give a brief history of injury or condition.

11.) Date of injury or onset of condition. _____