



CEDARS-SINAI MEDICAL CENTER
SPINE CENTER

Personal information

Last Name: _____ First Name: _____

Age: _____ Date of birth: _____ Occupation: _____ Not working

Social History

Marital Status: Single Married Separated Divorced Widowed

Do you live alone: Yes No

How many children do you have? _____ None

Will you have a caregiver to assist you if surgery is needed? Yes No

Are you currently working? Yes No

Have you lost work due to your back problem? Yes No

Do you have stairs in your home? Yes No

Do you think you are at risk for a fall? Yes No

Current Problems

Chief complaint or reason for visit: _____

Date symptoms began: _____

Cause of present problem (e.g. work related injury, auto accident, slip-and-fall, etc.):

Past History

Past or ongoing medical problems (e.g. high blood pressure, stroke, diabetes, heart condition, cancer, etc.):

(If more space is needed, please attach on a separate sheet.)



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Previous Surgeries

Name of operation:

Date:

Blank lines for entering surgery names and dates.

Other Information

Do you smoke? [] No [] Yes Number of cigarettes per day _____

Do you drink alcohol? [] No [] Yes Number of drinks per day _____

Have you had imaging in the last 3 months?

[] No [] Yes [] MRI [] CT scan [] X-rays

Allergies

Please list all allergies and response such as rash, itching, difficulty breathing, or unknown:

Drug name

Reaction

Blank lines for listing allergies and reactions.

Medications

Please list all current medications, over the counter drugs, vitamins and herbals.

Please give us the total number of "as needed" medication taken in a 24-hour period.

Table with 4 columns: Name, Dosage / Amount, Time of day, Total taken in 24 hrs. Multiple rows for medication entry.

Signature

Date

Time