Cedars-Sinai Medical Center®
Spine Center

Personal information

Last Name: ______________________________ First Name: ______________________________

Age: _______ Date of birth: _______________ Occupation: ______________________________

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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CEDARS-SINAI MEDICAL CENTER®
SPINE CENTER

Previous Surgeries

Name of operation:	Date:
______________________________	______________
______________________________	______________
______________________________	______________

Other Information

Do you smoke? ❑ Yes ❑ No

If yes, number of cigarettes per day: ________

Do you drink alcohol? ❑ Yes ❑ No

If yes, what kind of drink(s)? ______________________________

Number of drinks per week: ________

Have you had recent imaging studies? ❑ Yes ❑ No

________ MRI ________ CT scan ________ Plain X-rays

Allergies

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

Drug name	Reaction
______________________	______________________
______________________	______________________
______________________	______________________

Medications

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

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

Name	Dosage / Amount	Time of day
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

Signature	Date	Time