Cedars Sinai | Orthopaedic Surgery
Trauma and Adult Reconstruction

Carol A. Lin, MD, MA; Milton T. M. Little, MD; Geoffrey S. Marecek, MD; Charles N. Moon, MD; Mark S. Vrahas, MD, MHCDS

NEW PATIENT INFORMATION

PATIENT I.D.

Last Name: _____ First Name: _____ MI: _____

Age: _____ Date of Birth: _____ Occupation: _____ ❑ Not Working

Family History of: Cancer ❑ No ❑ Yes Blood Clots ❑ No ❑ Yes Bleeding ❑ No ❑ Yes

Social History

With whom do you live? ❑ Spouse/Partner ❑ Children ❑ Parents/Siblings ❑ Roommate(s) ❑ Alone

How many children do you have: _____ ❑ None

Do you have someone to assist ~~you with~~ daily activities if needed? ❑ Yes ❑ No

Are you currently working? ❑ Yes ❑ No

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

Do you have stairs in your home? ❑ Yes ❑ No

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

Date symptoms began: _____

Current Problems

Chief complaint or reason for visit: _____

_____

_____

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

_____

What favorite activities does your pain prevent?: _____

_____

Can you care for yourself? *(e.g. dressing, eating, toileting, standing up, etc.):*

_____

Other difficult functions include: _____

Have you experienced any recent (check all that apply):

Weight change	❑	Thyroid problems	❑	Dizziness	❑
Bleeding	❑	Diabetes	❑	Stroke	❑
Blood clots	❑	Blood transfusion	❑	Seizures	❑
Heart problems	❑	Difficult walking	❑	Epilepsy	❑
Blood pressure	❑	Swollen legs	❑	Cancer	❑
Pacemaker	❑	Joint pain	❑	Easy bruising	❑
Hearing	❑	Arthritis	❑	Skin problem	❑
Eye problems	❑	Bone disease	❑	Mental illness	❑
Nosebleeds	❑	Back problems	❑	Are you pregnant?	❑
Difficulty swallowing	❑	Gout	❑		

Are you experiencing pain now? ❑ Yes ❑ No

If yes, where is the location of your pain? _____

Form No. 10713-A (Rev. 5/1/2020) Front

Cedars Sinai | Orthopaedic Surgery
Trauma and Adult Reconstruction

Carol A. Lin, MD, MA; Milton T. M. Little, MD; Geoffrey S. Marecek, MD; Charles N. Moon, MD; Mark S. Vrahas, MD, MHCDS

NEW PATIENT INFORMATION

PATIENT I.D.

How much pain do you feel now? 0 1 2 3 4 5 6 7 8 9 10
(On scale of 0-10, with 10 being the most painful, please circle what you are feeling right now)

How much pain can you tolerate? 0 1 2 3 4 5 6 7 8 9 10
(On scale of 0-10, with 10 being the most painful, please circle what you can tolerate)

Does this pain prevent you from: Working? Walking? Doing daily activities? Sports?

If so, what activity? _____

Have you taken any pain medications within the last 24 hours? ❑ No ❑ Yes

If you have taken medication for pain, what did you take? _____ How much? _____

Past History

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

Previous Surgeries

Name of operation:	Date:

Other Information

Do you drink alcohol? ❑ No ❑ Yes How often? _____

Do you use tobacco products? ❑ No ❑ Yes How often? _____

Do you use marijuana products? ❑ No ❑ Yes How often?

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

Name	Dosage	Time of Day	Total taken in 24 hours

Patient / Guarantor Printed Name	Patient / Guarantor Signature	Date	Time
CSMC Representative Printed Name	CSMC Representative Signature	Date	Time