Summit Orthopedic Surgery, A Division of The Centers for Advanced Orthopaedics

Patient's Vitals/Medical Information

Has the patient been seen as a NEW PATIENT within the last 90-days: Yes ___ No ___

Patient Name: ____

Date of Birth: ____/____/______ Pharmacy Name & Number _______________________________

Weight: (last known is OK)____________________________Height: _____________________________

Smoking Status: Current every day smoker ___ Current "some days" smoker ___
Former smoker ___ Never smoked ___

Current Medical Conditions: Please check here if none ___

______________________ ______________________ ______________________________
______________________ ______________________ ______________________________
______________________ ______________________ ______________________________

Current Medications AND Dosage Plus frequency: Please check here if none _____

______________________ ______________________ ______________________________
______________________ ______________________ ______________________________
______________________ ______________________ ______________________________
______________________ ______________________ ______________________________

Current Allergies: Please check here if none ___

______________________ ______________________ ______________________________
______________________ ______________________ ______________________________
______________________ ______________________ ______________________________

Preferred Language: English: ___ Spanish: ___

Race:
American Indian/Alaska Native: ___
Black/African American: ___
White/Caucasian: ___
Asian: ___
Other: ___

Ethnicity: (If no response is given, your choice will be automatically selected as "Decline to Answer")

Hispanic: ____ Non-Hispanic: ____ Decline to Answer: ____ Unknown: ____

I hereby certify that the above information is true and correct.

Patient Signature: ______________________________________ Date: _________________________