

CINCINNATI BONE & JOINT INSTITUTE

Patient Demographics:

Patient Name: _____
First MI Last Preferred Name

SS#: _____ Birth date: _____ Sex: *Male Female*

Address: _____
Street Address City/State Zip Code

Home # _____ Cell # _____ Work # _____
(Include area cod) (Include area code) (Include area code)

Marital Status: *M S D W* E-Mail Address: _____

Primary Care Physician (first & last name) Dr. _____

Pharmacy (name & phone #) _____

Guardian Information (If Patient is a Minor):

Name: _____ Relationship to Patient _____

SS#: _____ Birth date: _____ Sex: *Male Female*

Address: _____
Street Address City/State Zip Code

Home # _____ Cell # _____ Work # _____
Include area code Include area code Include area code

Please list any **Medications** that you are currently taking:

MEDICATION	DOSE	DR.	MEDICATION	DOSE	DR.
1)			6)		
2)			7)		
3)			8)		
4)			9)		
5)			10)		

Do you have any **allergies** to medications / substances / LATEX? Yes No
 (If yes, please list): _____

Family Medical History: Please list major illnesses that affect immediate family:

MEDICAL ILLNESS	RELATION	MEDICAL ILLNESS	RELATION
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Social History:

Alcohol intake: Yes No Drinks per week: _____

Chewing Tobacco: Yes No Years: _____

Illicit Drugs: Yes No Type: _____

Smoking: Yes No Packs per day: _____ Years: _____

Tobacco - years of use _____ years