

**BRIAN E. REISS, M.D.**  
**ORTHOPEDIC SURGERY**  
**SPECIALIZING NECK & SPINE**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

What hand do you write with? Right \_\_\_\_\_ Left \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

HOW WOULD YOU RATE YOUR HEALTH? EXCELLENT \_\_\_ GOOD \_\_\_ FAIR \_\_\_ POOR \_\_\_

**SOCIAL HISTORY:**

Do you smoke? YES NO QUIT If yes, how many cigarettes per day? \_\_\_\_\_

Do you drink alcohol? YES NO If yes, how much? \_\_\_\_\_ how often? \_\_\_\_\_

Are you at risk for HIV / AIDS? Yes No Have you been tested? Yes No Results? \_\_\_\_\_

**ALLERGIES:**

Medication Allergies? YES NO Please List Allergies: \_\_\_\_\_

Adhesive Allergies? YES NO Are you allergic to latex? YES NO Have you been tested? \_\_\_\_\_

What medications do you take? Please list all meds including herbals, vitamins, recreational, and over the counter.

Current pharmacy phone number: \_\_\_\_\_ Do we have permission to download Rx's? \_\_\_\_\_

**FAMILY HISTORY:**

Has anyone in your family had a heart attack before age 55? Yes No

Have you ever had a bad reaction to anesthesia? Yes No

Do you bruise or bleed easily? Yes No

Please list all hospitalizations and surgery:

On the back of this form are questions about your health and medical history. This form must be updated yearly. Please complete it as accurately as possible, and be sure to sign and date the form when it is complete. All information will be kept confidential. Thank You.