

Dr. Shapiro's New Patient Health History Form

PAST MEDICAL HISTORY

Surgeries (Circle all that apply)

None		
Appendectomy	Gall Bladder Removal	Tonsillectomy
Back Surgery	Hernia Repair	Tubal Ligation
D & C	Hysterectomy	Vasectomy
Hip Replacement – R/L	Knee Replacement – R/L	Spinal Fusion
Knee Arthroscopy – R/L	Shoulder Arthroscopy – R/L	Laminectomy
Carpal Tunnel Release – R/L	Hip Arthroscopy – R/L	
Other _____		

Were there any anesthetic problems? Yes No

If yes, what were they? _____

*Any history of Blood Clots (DVT, PE) or bleeding problems postoperatively? Yes No

Have you had a broken bone(s)? Yes No

If yes, which bone(s)? _____

Medical History (Circle all that apply)

None			
AIDS/HIV	Emphysema/COPD	High Blood Pressure	Substance Abuse
Anemia	Gallstones	Kidney Disease	Stroke
Anxiety	Gastrointestinal Bleeding	Multiple Sclerosis	Thyroid Problems
Asthma	Gout	(Osteo) Arthritis	Tuberculosis
Blood Disorders	Heart Attack/Disease	(Rheumatoid) Arthritis	Ulcers
Cancer _____	Hepatitis	Alzheimer's/Dementia	Depression/Anxiety
Diabetes	Other _____		

Current Medications and Doses: (please attach a copy of Med List, if available)

1.	5.
2.	6.
3.	7.
4.	8.

Medicine Allergies (and the reaction):

1.	3.
2.	4.

Family History (Circle all that apply)

None			
AIDS/HIV	Emphysema	High Blood Pressure	Ulcers
Anemia	Gallstones	Mental Health Problems	
Arthritis	Gastrointestinal Bleeding	Multiple Sclerosis	
Asthma	Gout	Stroke	
Blood Disorders	Heart Disease	Thyroid Problems	
Cancer	Hepatitis	Tuberculosis	
Diabetes	Other _____		

Has any family member had a problem with anesthesia? Yes No

If yes, what was the problem? _____

Has any family member had a blood clot (DVT, PE) or bleeding problem? Yes No

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Review of Systems: (circle all that apply)

General: Fever, chills, generalized weakness, fatigue, significant weight change without trying. _____

Respiratory: Shortness of breath, cough, asthma, bronchitis, wheezing _____

Cardiac: Chest pains, irregular heartbeat, palpitations, Pacemaker, Rheumatic Fever _____

Vascular: Claudication, varicose veins, peripheral cyanosis, venous malformations _____

Gastrointestinal: Heart burn, indigestion, change in bowel habits, bloody or dark stools _____

Musculoskeletal: other joint (stiffness, pain, swelling, redness), muscle (aches, spasms), extremity (weakness, atrophy, deformity), Multiple Sclerosis, fibromyalgia, atrophy, arthritis
Describe _____

Neurological: Seizures or epilepsy, balance problems, extremity numbness or tingling, headache, dizziness/vertigo, TIA/CVD _____

Endocrine: Increased thirst, increased appetite, hyper/hypo activity, growth/hair changes _____

Hematopoietic: Easy bruisability, easy bleeding, sickle cell disease, anemia _____

Skin: Rashes, ulcers, discoloration, lesions, scars, masses, dryness _____

Genitourinary: blood in urine, urine infections, kidney stones, STD, burning on urination _____

Ear/Nose/Throat: ears ringing, hearing aids, earaches, frequent colds, nasal discharge, nosebleeds, hay fever, dentures, bleeding gums, frequent sore throats _____

Eyes: Glasses/contacts, blurred vision, glaucoma, cataracts, excessive tearing _____

Social History

Marital Status: Single Married Separated Divorced Widowed
Children: Yes No _____ Son(s) _____ Daughter(s)

Habits: Do you use?

Tobacco Yes No How much? _____
Alcohol Yes No How much? _____
Recreational Drugs Yes No Which Drugs? _____
Caffeine Yes No How much? _____

Exercise Habits (circle): Daily 3-5x/week 1-2x/week 1x/month None
Type of Exercise: _____

Vital Signs:

Height _____ **Weight** _____ **BP** _____ **Pulse** _____ **Resp** _____

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Work History

Are you working? Yes No (if No, Circle one) – **Unemployed, Disabled, Retired**

If **no**, date last worked? _____ (Please skip to next section)

If **yes**, is it? **Full duties** or **Light/Modified duties** (When did this start? _____)

Job Title and Description

How physically demanding is your present job?

Very heavy (frequently lifting >100#) _____

Heavy (frequently lifting >80#) _____

Moderate (frequently lifting >30#) _____

Light (frequently lifting <30#) _____

Sedentary (essentially no lifting) _____

How many hours do you work in a day? _____ **week?** _____

How are your rest periods structured? _____

Years at present position: _____

What motions, if any, do you perform on a repetitive basis?

How often do you repeat this motion? _____

How frequently does your job require you to be in the following positions?

	Frequently	Occasionally	Rarely
Arms over shoulder height	_____	_____	_____
Sitting	_____	_____	_____
Standing	_____	_____	_____
Crouching/Squatting	_____	_____	_____
Kneeling	_____	_____	_____
Crawling	_____	_____	_____
Driving	_____	_____	_____

If you are presently on light/modified duty, please describe your present work:
