David S. Weiss, MD

MEDICAL HISTORY

Name: _____ Date: _____

Height: _____(feet/inches or cm)

My weight is: ☐ About where it should be ☐ Too high ☐ Too low

I am: ☐ Right hand dominant ☐ Left hand dominant ☐ Ambidextrous _____

In order to provide you with the best possible care, I ask that you provide information regarding your medical history. Please answer "Yes" or "No" for each question. If you answer "Yes," please explain by entering the details.

Musculoskeletal History

Please describe the medical problem for which you are consulting me, including: where it's located; what you feel; whether it radiates elsewhere; when it started; how it started; how you have treated it. (This information will assist me in ordering appropriate x-rays before your visit.)

☐ YES ☐ NO Do you presently have any other bone, joint, muscle, or nerve problems other than the ones for which you are seeking consultation today? Include side:

☐ YES ☐ NO Have you previously had any bone, joint, muscle, or nerve problems or injuries? *If yes, please describe problem(s), side of body, and approximate year(s) –* ***especially if it was in the same area as your current problem****:*

Family History

Do any members of your immediate family (blood relatives) have: ☐ Adopted (history unknown)

☐ YES ☐ NO Arthritis, gout, or any other bone, joint, muscle, or nerve problems (excluding traumatic injuries)? *If yes, please describe:*

Family History *(continued)*

☐ YES ☐ NO Serious medical problems? *If yes, please describe:*

Systems Review (symptoms)

Do you have *(if yes, please describe briefly):*

☐ YES ☐ NO Weight loss? _____

☐ YES ☐ NO Fevers? _____

☐ YES ☐ NO Frequent or severe headaches? _____

☐ YES ☐ NO Numbness or tingling? _____

☐ YES ☐ NO Double or blurry vision? _____

☐ YES ☐ NO Dizziness? _____

☐ YES ☐ NO Cough? _____

☐ YES ☐ NO Chest pain? _____

☐ YES ☐ NO Shortness of breath? _____

☐ YES ☐ NO Excessive bleeding when cut? _____

☐ YES ☐ NO Frequent nose bleeds? _____

☐ YES ☐ NO Nausea? _____

☐ YES ☐ NO Heartburn? _____

☐ YES ☐ NO Burning or pain with urination? _____

☐ YES ☐ NO Excessive or frequent urination? _____

☐ YES ☐ NO Skin rash? _____

☐ YES ☐ NO Swelling of feet or ankles? _____

☐ YES ☐ NO Depression? _____

General History (conditions, diseases)

Have you ever had or do you now have *(if yes, please give details, including approximate dates):*

☐ YES ☐ NO Hypermobility (loose-jointedness)? _____

☐ YES ☐ NO Rheumatoid (inflammatory) arthritis? _____

☐ YES ☐ NO Lupus? _____

☐ YES ☐ NO Other collagen-vascular (auto-immune) disorders? _____

☐ YES ☐ NO Gout? _____

☐ YES ☐ NO Osteoporosis or osteopenia? _____

MEDICAL HISTORY

☐ YES ☐ NO Vitamin D deficiency? _____

☐ YES ☐ NO Diabetes? _____

☐ YES ☐ NO Thyroid disorders? _____

☐ YES ☐ NO Other endocrine disorders? _____

☐ YES ☐ NO Cancer? _____

☐ YES ☐ NO Anemia? _____

☐ YES ☐ NO Sickle cell anemia? _____

☐ YES ☐ NO Bleeding disorders? _____

☐ YES ☐ NO Thrombophlebitis or blood clots? _____

☐ YES ☐ NO Other blood disorders? _____

☐ YES ☐ NO Dermatitis? _____

☐ YES ☐ NO Psoriasis? _____

☐ YES ☐ NO Other skin disorders? _____

☐ YES ☐ NO Glaucoma? _____

☐ YES ☐ NO Cataracts? _____

☐ YES ☐ NO Other eye problems? _____

☐ YES ☐ NO Deafness? _____

☐ YES ☐ NO Other ear, nose, or throat disorders? _____

☐ YES ☐ NO Epilepsy or seizures? _____

☐ YES ☐ NO Stroke? _____

☐ YES ☐ NO Concussion? _____

☐ YES ☐ NO Other neurologic disorders? _____

☐ YES ☐ NO Covid-19? _____

☐ YES ☐ NO Lyme disease? _____

☐ YES ☐ NO Hepatitis? _____

☐ YES ☐ NO Infectious mononucleosis? _____

☐ YES ☐ NO HIV infection? _____

☐ YES ☐ NO AIDS? _____

☐ YES ☐ NO Methicillin-resistant Staph aureus (MRSA) infection? _____

☐ YES ☐ NO Pneumonia? _____

☐ YES ☐ NO Other infectious diseases? _____

☐ YES ☐ NO Heart attack? _____

☐ YES ☐ NO Elevated cholesterol or trigylcerides? _____

☐ YES ☐ NO High blood pressure? _____

☐ YES ☐ NO Rheumatic fever? _____

☐ YES ☐ NO Irregular heart beat? _____

☐ YES ☐ NO Heart murmur? _____
If yes, were you advised to take any medication? ☐ YES ☐ NO

☐ YES ☐ NO Other heart disorders? _____

☐ YES ☐ NO Asthma? _____

☐ YES ☐ NO Emphysema? _____

☐ YES ☐ NO Other lung or breathing disorders? _____

☐ YES ☐ NO Reflux ("GERD")? _____

☐ YES ☐ NO Ulcers of the stomach or intestine? _____

☐ YES ☐ NO Gall bladder disease? _____

☐ YES ☐ NO Liver disease? _____

☐ YES ☐ NO Other digestive disorders? _____

☐ YES ☐ NO Recurrent urinary tract infections? _____

☐ YES ☐ NO Other kidney, bladder or urine disorders? _____

☐ YES ☐ NO Men: Prostate disease? _____

☐ YES ☐ NO Women: Menopause? _____

☐ YES ☐ NO Women: Amenorrhea (absence of menstrual periods)? _____

☐ YES ☐ NO Women: Other gynecologic disorders? _____

☐ YES ☐ NO Eating disorders or anorexia nervosa? _____

☐ YES ☐ NO Bulimia? _____

☐ YES ☐ NO Persistent anxiety or nervousness? _____

☐ YES ☐ NO Persistent depression? _____

☐ YES ☐ NO Other psychological disorders? _____

☐ YES ☐ NO Have you had **surgery** not described anywhere above?
If yes, please list type of surgery (including side of body) and date:

☐ YES ☐ NO Have you been treated for or do you now have other **illnesses or injuries** not described anywhere above? *If yes, please give details:*

☐ YES ☐ NO Do you have any dietary or nutritional restrictions? *If yes, please give details:*

☐ YES ☐ NO Do you use cigarettes, cigars, a pipe, marijuana or other substances, or use e-cigarettes or a vaporizer? *If yes, please indicate type and amount of each:*

☐ YES ☐ NO Are you in recovery?
If yes, please indicate substance(s) or illness(es) (if you wish):

Immunizations

☐ YES ☐ NO Have you received vaccinations for tetanus?

Date of last booster shot: _____ (Tetanus booster required every 10 years)

☐ YES ☐ NO Have you received vaccinations for Covid-19?
If yes, please enter date and type of most recent booster:

Allergies

☐ YES ☐ NO Do you have an **allergy** to latex?

☐ YES ☐ NO Do you have any **allergies** to any medications?
If yes, please list medications (and reactions, if known):

☐ YES ☐ NO Do you have any **allergies** to any other items (foods, *etc.*)?
If yes, please list items (and reactions, if known):

Current Medications and Supplements

☐ YES ☐ NO Do you take any prescription medications? *If yes, please list:*

Name of medication	Dose (mg, times per day)	What the medication treats

☐ YES ☐ NO Do you take any "over-the-counter" medications or pills (including herbals and supplements)? *If yes, please list:*

Name of medication/supplement	Dose (mg, times per day)	What the medication treats

Pharmacies

Prescription medications will be prescribed electronically, as required by law.
You will not receive a paper prescription.
If you do not have a pharmacy, search for and choose at least one.
Please enter:

Required – Preferred Pharmacy Name: _____

Address: _____

City: _____ State: _____ Zip (*required*): _____

Optional – *Alternate Pharmacy Name*: _____

Address: _____

City: _____ State: _____ Zip (*required*): _____

Health Care Providers

Primary Physician ☐ I don't have one

Your internist, family practitioner, or gynecologist, *etc.*

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

☐ YES ☐ NO Are you under the regular care of any other **health care practitioners** (medical specialist, psychologist, physical therapist, nutritionist, chiropractor, massage therapist, acupuncturist, *etc.*)? *If yes, please enter:*

Name: _____

Location: _____

Type of practitioner: _____

Name: _____

Location: _____

Type of practitioner: _____

Name: _____

Location: _____

Type of practitioner: _____

Name: _____

Location: _____

Type of practitioner: _____

Please provide any other information that you would like me to know:

I have answered all the above questions completely and truthfully, to the best of my knowledge.
I authorize review of my medical information in electronic systems, including but not limited to Epic, Commonwell, and the Health Information Exchange.
If I file an insurance claim, I authorize the release of any medical or other information necessary to process the claim.
If I communicate with the office via text or email, I understand that the information in these messages may be susceptible to interception by a third party and therefore may not be private.

_____ _____

Patient's Signature Date