

David S. Weiss, M.D.

Orthopaedic Surgery · Sports Medicine · Performing Arts Medicine

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Please print legibly:

Date: _____ / _____ / _____

Name (full legal): _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Sex: Male Female Birthdate: _____ / _____ / _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other _____: (_____) _____

Email address
(use BLOCK letters): _____

Soc. Sec. # _____ Occupation: _____

Marital Status: Minor Single Married Long term partner Divorced Separated Widowed

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Relation: _____ Home Phone: (_____) _____

Work Phone: (_____) _____ Cell Phone: (_____) _____

Referred by: _____

(If you were referred by a physician, please enter the physician's name and address on next page)

Please complete medical history beginning on next page ↻

FOR OFFICE USE ONLY:

Enter the name of your physician (internist, family practitioner, gynecologist, etc.):

Physician's full name: _____ None

Phone: (_____) _____ Fax: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

YES NO Are you presently under the care of any other physicians or health care providers (podiatrist, chiropractor, psychologist)? If yes, enter:

Name: _____ Phone: (_____) _____

Specialty of provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____ Phone: (_____) _____

Specialty of provider: _____

Address: _____

City: _____ State: _____ Zip: _____

In order to provide you with the best possible care, I ask that you carefully complete all of the following questions regarding your symptoms and medical history:

Please CHECK the appropriate box for each question:

YES NO Do you presently have any other bone, joint, muscle, or nerve problems other than the one(s) for which you are seeking consultation? If yes, please describe:

YES NO Have you previously had any bone, joint, muscle, or nerve problems or injuries? If yes, please describe problem(s) and date(s):

YES NO Do any members of your family (blood relatives) have arthritis, gout, or any bone, joint, muscle, or nerve problems (excluding traumatic injuries)? If yes, please describe:

Do you have (if yes, please describe):

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? _____

.

YES NO Have you had any surgery? If yes, please list type of surgery and year:

*Have you ever had or been treated for, or do you now have:
(If yes, please give details including the year that the problem began):*

- YES NO Rheumatoid arthritis? _____
- YES NO Lupus? _____
- YES NO Other collagen-vascular (auto-immune) disorders? _____
- YES NO Gout? _____
- YES NO Osteoporosis? _____
- YES NO Cancer? _____
- YES NO Diabetes? _____
- YES NO Thyroid disorders? _____
- YES NO Other endocrine disorders? _____
- 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 Lyme disease? _____
- YES NO Hepatitis? _____
- YES NO Infectious mononucleosis? _____
- YES NO HIV infection? _____
- YES NO AIDS? _____

- YES NO Pneumonia? _____
- YES NO Other infectious diseases? _____
- YES NO Heart attack? _____
- YES NO Elevated cholesterol or triglycerides? _____
- 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 Esophageal reflux? _____
- 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 persistent psychological disorders? _____
- YES NO Have you received immunizations for tetanus?
Date of last booster shot: _____ (Booster shot is required every 10 years)

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

YES NO Do you have any **allergies** to any drugs or medications? To latex or iodine? If yes, please list item(s) & reaction(s):

YES NO Do you take any prescription medications? If yes, please list (or attach info):
Medication name Dose (if known) What the medication is for (purpose)

YES NO Do you take any "over-the-counter" medications or pills (including herbals and supplements)? If yes, please list name(s) and how often you use each:

YES NO Do you smoke cigarettes, cigars, or a pipe? If yes, indicate type and amount:

All of the above questions have been answered completely and truthfully, to the best of my knowledge. I authorize review of my medical information in the NYU Electronic Data Repository. If I file an insurance claim, I authorize the release of any medical or other information necessary to process the claim.

Patient's Signature

Date



Reviewed:

David S. Weiss, M.D.