

**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 (optional): \_\_\_\_\_

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 referred by physician, please enter 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 personal 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: \_\_\_\_\_

.....  
To help give you the best possible care, please 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:

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*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? \_\_\_\_\_

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

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

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

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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)

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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:

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

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*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.