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HEALTH HISTORY

1. Today's Date: _____

2. Name: _____ 3. Age: _____

4. Primary Care Doctor: _____

5. Referring Doctor (if different) _____

6. Reason for today's visit:

7. Medications/Supplements	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

8. Any other health Problems:

9. Do you have any medication allergies? No Yes If so, please list below.
_____ Reaction: _____

10. Do you smoke? No Yes How much and for how long? _____

11. Do you ever use alcohol? No Yes How much? _____

12. Are you allergic to: latex (e.g. dentist gloves)? No Yes

13. Have you been treated with steroids in the past 2 years?(e.g., prednisone, Medrol) _____

14. Please list past surgeries with dates (month/year) and if you experienced any problems during or after surgery. (i.e. anesthesia problems, nausea or vomiting)

15. Is someone available to care for you and stay overnight with you if you need to have surgery?

Yes No

16. Does anyone in your family (blood relatives) have high fever from anesthesia? Bleeding, healing or scarring problems? Yes No

17. What do you do for work? _____

18. What do you enjoy or do for fun? _____

19. Please check if you have or have had any of the following conditions. (please specify)

Yes No

Difficulties with eyes, ears, nose or throat _____

Thyroid trouble or diabetes _____

Heart or circulation problems or increased blood pressure _____

Lung problems/breathing problems _____

Gastrointestinal difficulties or digestive trouble/liver problems _____

Kidney or urinary tract problems _____

Difficulties with male or female organs/breasts _____

Trouble with balance or coordination/feeling in your hands or feet? _____

Neurological or nerve problems (e.g. seizures, slipped disc, numbness/tingling) _____

Skin difficulties _____

Arthritis, rheumatism or trouble with your muscles _____

Bleeding, anemia or blood diseases _____

Highs or lows of mood or panic attacks _____

20. If you are a woman when was your last mammogram? _____