

James M. Shenko, M.D.  
Plastic/Hand Surgery  
299 Lincoln Street  
Worcester, MA 01605  
Tel # (508) 852-2001  
Fax # (508) 852-3001

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Language Spoken: \_\_\_\_\_

Please complete the following medical history questions:

**Past/Present Medical History:** check box & explain

<input type="checkbox"/> Patient denies any past/present medical history
<input type="checkbox"/> Acid Reflux
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma/Allergies
<input type="checkbox"/> Autoimmune Disease
<input type="checkbox"/> Bleeding disorder, anemia
<input type="checkbox"/> Breast Cancer
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chest Pain/tightness
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Hypothyroid
<input type="checkbox"/> Kidney or urinary tract problems
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Lung Disease/COPD
<input type="checkbox"/> Migraines
<input type="checkbox"/> Neurological or nerve problem
<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Skin Disease/Eczema
<input type="checkbox"/> Stomach/Gastrointestinal problem
<input type="checkbox"/> Other:
<input type="checkbox"/> Other:
<input type="checkbox"/> Other:

**Social History**

**Do you use alcohol?**  never  seldom  socially  
 daily  hx alcoholism  other \_\_\_\_\_

Have you had a problem with pain medication addiction (past/present)?  no  yes, please explain  
\_\_\_\_\_

**Smoking status:**  non-user  tobacco  
 smokeless tobacco user (eg. chew, snuff)

How much? \_\_\_\_\_ How long? \_\_\_\_\_  
When quit? \_\_\_\_\_

Where do you work and what do you do for work?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergy History**

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

\_\_\_\_\_ Reaction: \_\_\_\_\_  
\_\_\_\_\_ Reaction: \_\_\_\_\_  
\_\_\_\_\_ Reaction: \_\_\_\_\_

**Are you allergic to latex?** (i.e. dentist gloves)

No  Yes Reaction: \_\_\_\_\_

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

	Surgery	Date	Anesthesia Complications	Notes
1				
2				
3				
4				
5				
6				

**Medications/Supplements (mg & directions):**

**Reason why you take this medicine:**


**What pharmacy do you use?** \_\_\_\_\_ **Address:** \_\_\_\_\_  
**Pharmacy Phone Number:** \_\_\_\_\_

Have you been treated with steroids in the past 2 years? (i.e. Prednisone, Medrol) \_\_\_\_\_

**Patient's ability to heal:**

- Does your skin appear fragile, burns easily? No  Yes
- Do you form thick or raised scarring from a cut or burn? No  Yes
- Do you wax or use depilatories on your face? No  Yes
- Do you ever get cold sores? No  Yes
- Do you have diabetes? No  Yes

**Patient's present:** weight \_\_\_\_\_ height \_\_\_\_\_

**Female History**

**Yes No N/A Note Date**

	Yes	No	N/A	Note	Date
Do you have regular periods?					
Are you going through menopause?					
Are you pregnant or lactating?					
During pregnancy, did you ever get hyperpigmentation or masking?					
Are you done having children?					
Did you nurse your children?					

How many pregnancies have you had? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

What are the ages of your children? \_\_\_\_\_

**Mammogram**

When was your last mammogram? \_\_\_\_\_

Was your last mammogram normal? \_\_\_\_\_. If not, please explain \_\_\_\_\_

When is your next mammogram scheduled? \_\_\_\_\_