James M. Shenko, M.D.
Richard D. Montilla, M.D.
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

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

Social History

Do you use alcohol? ☐ never ☐ seldom ☐ socially
☐ daily ☐ hx alcoholism ☐ other_________________

Have you had a problem with pain medication adiction (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**
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? ________________________