Shoulders & Knees
Steven Struhl MD

REGISTRATION

Name ____________ Age ____ Date of Birth ________

Address ____________ Married ☐ Single ☐

____________ Social Security # ________

Cell phone # ____________ Occupation ________

Home phone # ____________ Employer Name ________

Business phone # ____________ Medical Doctor ________

Email ____________ Medical Doctor phone # ________

Emergency Contact Name ____________ Emergency Phone # ________

Please circle: ↓

Referral Information (how did you get referred to our office?)	Hand Dominance: Rt -or- Lt

What is your main symptom? BODY Part + side: ↓↓

Did you have an injury? ☐ Yes ☐ No If yes, what was the **date**? ________

If yes, was it ☐ **Automobile** related or ☐ **Work** related?

If there was no specific injury how long have you had symptoms? ________

Do you have any allergies to prescription drugs? ☐ Yes ☐ No If yes, which? ________

What prescription medication are you currently taking? Please list:

Do you have any medical problems such as high blood pressure, diabetes, heart disease, asthma, seizures, hepatitis, anemia or any other? Please circle and/or explain below:

Have you ever had a stress test and if so when?

What is your height and weight? BP:

Do you smoke? ☐ Yes ☐ No If yes, how much?

ASSIGNMENT AND RELEASE

I, the undersigned have insurance coverage with ____________________
and assign directly to **Dr. Struhl** all medical benefits, if any , otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

____
Signature of Insured/Guardian Date

Patient Medical History

Patient Name	Date of Birth
Primary Care Provider Dr.:______	Cardiologist/Specialist Dr.:______
Ph:______	Ph:______
Diagnosis:______	Surgeon:______
Surgical Procedure:______	Ph:______
METS Score (nurses use only): Wheelchair bound? Bedridden?	Height: Weight:

	YES	NO		YES	NO
Do you have or are you being treated for high blood pressure? *If yes, how many years?*______	☐	☐	Have you ever had a heart valve replacement or repair?	☐	☐
Do you have chest pain with walking/normal activity? With exercise?	☐	☐	Do you have a pacemaker or defibrillator?	☐	☐
Have you ever had a coronary bypass or angioplasty?	☐	☐	Have you ever been told that you have a widening of your aorta or that you have an aortic aneurysm?	☐	☐
Have you ever had a heart attack? *If yes, how many?:* ______ *When?:* ______	☐	☐	Have you ever been told you have peripheral vascular disease?	☐	☐
Do you have a heart stent? *If yes, how many?:* ______ *When?:* ______	☐	☐	Have you ever had a stress test? *If yes, where?:* ______ *When?:* ______	☐	☐
Do you have a weak or failing heart (congestive heart failure, CHF)?	☐	☐	Have you ever had a cardiac echo test? *If yes, where?:* ______ *When?:* ______	☐	☐
Do you have an irregular heartbeat or heart rhythm?	☐	☐	Have you ever had a heart catheterization? *If yes, where?:* ______ *When?:* ______	☐	☐
Do you have a heart murmur or mitral valve prolapse?	☐	☐			
Do you take daily medication for asthma?	☐	☐	Do you have difficulty breathing (do you wheeze)?	☐	☐
Do you have a history of chronic bronchitis or emphysema (COPD)?	☐	☐	Do you use supplemental oxygen?	☐	☐
Do you smoke? *If yes, how many packs / day:*____ *How may years have you been a smoker?:* ______	☐	☐	Do you have a history of sleep apnea? CPAP?	☐	☐
Have you had any recent colds, fever or flu symptoms?	☐	☐	Have you ever been witnessed to stop breathing while asleep?	☐	☐
Do you have diabetes? *If yes, for how many years?:*______ *Complicatians?:*______	☐	☐	Do you take insulin?	☐	☐
Do you have kidney problems (other than kidney stones)?	☐	☐	Have you ever had Hepatitis A / B / C / D? (circle)	☐	☐
Do you have liver problems?	☐	☐			
Do you drink alcohol every day? *If yes, how many drinks/day:*______	☐	☐	Do you use recreational drugs? *If yes, specify*______	☐	☐

Please Turn Over To Continue

Patient Medical History

	YES	NO		YES	NO
Do you have a history of anemia?	☐	☐	Do you have a history of sickle cell disease or trait?	☐	☐
Do you take any blood thinners (e.g. Coumadin)?	☐	☐	Do you have a history of cancer?	☐	☐
Do you take Aspirin or Ibuprofen regularly?	☐	☐	Are you on Chemo Therapy?	☐	☐
Do you have seizures or take anti-seizure medications?	☐	☐	Do you have neuromuscular disease (including Parkinson's, ALS etc)?	☐	☐
Have you ever had a stroke(CVA), mini stroke(TIA) or brain attack? *If yes, when?:* ______	☐	☐	Do you have a brain tumor, brain aneurysm or other vascular lesion of the brain?	☐	☐
Have you been told that it is difficult to place a breathing tube in your airway (intubate)?	☐	☐	Do you have a history of severe reaction to anesthesia?	☐	☐
Do you or a family member have a history of high fever after anesthesia (malignant hyperthermia)?	☐	☐	Do you suffer from chronic pain?	☐	☐
Do you have a history of severe nausea and vomiting after anesthesia?	☐	☐	Is there a possibility you could be pregnant? *LMP:* ______	☐	☐
Do you have an autoimmune disease (such as Rheumatoid Arthritis, Sarcoidosis or Lupus)?	☐	☐	Do you have any other medical problems that we have not asked you about? *If yes, specify:* ______	☐	☐

OFFICE USE: EKG results good for 6 months. Chemistry lab results good for 3 months.

Please list the medications you currently take and the dose.

Medication: ______ Dose: ______

Medication: ______ Dose: ______

Medication: ______ Dose: ______

Medication: ______ Dose: ______

Medication: ______ Dose: ______

Medication: ______ Dose: ______

Medication: ______ Dose: ______

e-Prescribing

Steven Struhl, MD is in the process of implementing e-Prescribing in our office.

E-Prescribing is a federally mandated initiative that requires all physicians prescribe in this manner.

E-Prescribing software sends prescriptions over the internet to your pharmacy in a safe way. This helps protect privacy of personal information.

E-Prescribing software lets your doctor see important information- like drug interactions and your prescription history.

The benefit to you:

1) Less confusion over handwritten prescriptions
2) Reduced possibility of medical errors
3) Less chance of adverse drug reactions
4) Fewer trips to drop off at pharmacy
5) A safer, faster, easier way to get your prescriptions filled

CONSENT

I agree that Steven Struhl, MD may request and use my prescription history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

__________________________________ ____________________

Patient Signature Date

PHARMACY NAME:____________________________

FULL ADRESS: ____________________________

TELEPHONE #: ____________________________

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Tel (914) 328-4111
Fax (212) 207-4656

NAME ______________________________

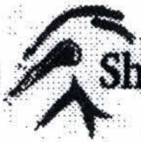
DATE: ______________________________

PLEASE CHECK

HIGH BLOOD PRESSURE	YES____ NO ___
DIABETES	YES____ NO___
ASTHMA	YES_____ NO___
LIVER DISEASE	YES_____ NO___
HISTORY OF CANCER	YES_____ NO___
(If yes, what kind & when)	____________
LOOSE TEETH DENTURES CAPS	YES_____ NO___
THYROID (HYPER OR HYPO)	YES_____ NO___
BLEEDING/BLOOD CLOT DISORDER	YES_____ NO___
CARDIAC STENTS	YES_____ NO____
SLEEP APNEA	YES_____ NO____
STROKE/HEART ATTACK	YES_____ NO____
SEIZURE DISORDER	YES_____ NO____

____

SIGNATURE



Shoulders & Knees
Steven Struhl MD

Authorization for Release of Information to Family Members

Patient Name____________________________ Date of Birth____________________________

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize **STEVEN STRUHL MD** to release my medical and/or billing information to the following individual(s):

1.____________________________ Relation to Patient:______________________

2.____________________________ Relation to Patient:______________________

3.____________________________ Relation to Patient:______________________

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature:____________________________ Date:______________________