Weill Cornell Medicine | NewYork-Presbyterian

Joan and Sanford I. Weill Medical College

Department of Neurological Surgery
525 East 68th Street, Box 99
New York, NY 10065

TODAY'S DATE: (mm/dd/yy)

MEDICAL HISTORY

Physician Name: Please check the name of the physician with whom you have an appointment.

- ☐ Dr. Heidi Bender
- ☐ Dr. Srikanth Boddu
- ☐ Dr. Babacar Cisse
- ☐ Dr. Georgiana Dobri
- ☐ Dr. Pierre Gobin
- ☐ Dr. Jeffrey Greenfield
- ☐ Dr. Caitlin Hoffman
- ☐ Dr. Michael Kaplitt
- ☐ Dr. Jared Knopman
- ☐ Dr. Susan Pannullo
- ☐ Dr. Rohan Ramakrishna
- ☐ Dr. Amanda Sacks-Zimmerman
- ☐ Dr. Theodore Schwartz
- ☐ Dr. Justin Schwarz
- ☐ Dr. Mark Souweidane
- ☐ Dr. Philip Stieg
- ☐ Other

PATIENT INFORMATION

PATIENT NAME: (First) | (Middle) | (Last)

ADDRESS: Street Name and # | City, State | Zip Code

TELEPHONE (Home): | TELEPHONE (Business): | TELEPHONE (Cell):

GUARANTOR NAME: (First) | (Middle) | (Last)

RELATIONSHIP OF GUARANTOR TO PATIENT: | GUARANTOR DATE OF BIRTH: (mm/dd/yy)

ADDRESS: Street Name and # | City, State | Zip Code

TELEPHONE (Home): | TELEPHONE (Business): | TELEPHONE (Cell): | E-MAIL:

DEMOGRAPHIC INFORMATION

DATE OF BIRTH: (mm/dd/yy) | AGE: | SEX: | NAME OF EMPLOYER:

MARITAL STATUS: | PREFERRED LANGUAGE SPOKEN: | OCCUPATION:

REFERRAL INFORMATION

HOW WERE YOU REFERRED?: *SELECT ONE*

☐ WEBSITE ☐ INSURANCE ☐ FAMILY / FRIEND ☐ PHYSICIAN ☐ EMERGENCY ROOM

☐ OTHER *(specify)* _____

☐ BRAIN/SPINE ORGANIZATION *(specify)* _____

REFERRING PHYSICIAN: | PHONE #: | FAX #:

ADDRESS: (Number, Street, City, State and Zip)

PRIMARY CARE PHYSICIAN: | PHONE #: | FAX #:

ADDRESS: (Number, Street, City, State and Zip)

SUB-SPECIALIST (1): | PHONE #: | FAX #:

ADDRESS: (Number, Street, City, State and Zip)

SUB-SPECIALIST (2) | PHONE #: | FAX #:

ADDRESS: (Number, Street, City, State and Zip)

MEDICAL HISTORY (Continued)

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PATIENT NAME

HEALTH INFORMATION

REASON FOR TODAY'S VISIT

OTHER DISEASES AND/OR PROBLEMS:

LIFESTYLE INFORMATION

DO YOU SMOKE?
☐ NO ☐ YES How many packs a day _____ How many years _____ ☐ QUIT - When _____

DO YOU DRINK ALCOHOL?
☐ NO ☐ YES How often _____ How much _____

DO YOU USE RECREATIONAL DRUGS?
☐ NO ☐ YES Which drugs _____ How often _____

DO YOU EXERCISE REGULARLY?
☐ NO ☐ YES How often _____ What type of exercise _____

DO YOU USE CHEWING TOBACCO OR SNUFF?
☐ NO ☐ YES How many years _____ ☐ QUIT - When _____

WHICH HAND DO YOU WRITE WITH?
☐ LEFT ☐ RIGHT

MEDICAL HISTORY

Please check YES or NO if you have experienced any of the following medical problems (select all that apply):

Anemia	☐ yes	☐ no	Fainting	☐ yes	☐ no	Neuromuscular Disease	☐ yes	☐ no
Arm Swelling	☐ yes	☐ no	Galactorrhea	☐ yes	☐ no	Parathyroid Disease	☐ yes	☐ no
Arm Weakness	☐ yes	☐ no	Glaucoma	☐ yes	☐ no	Rashes	☐ yes	☐ no
Asthma	☐ yes	☐ no	Gout	☐ yes	☐ no	Ringing in the Ears	☐ yes	☐ no
Bleeding Tendencies	☐ yes	☐ no	Headaches	☐ yes	☐ no	Seizure Disorder	☐ yes	☐ no
BPH (Enlarged Prostate)	☐ yes	☐ no	Hearing Loss	☐ yes	☐ no	Sexual Problems	☐ yes	☐ no
Cancer	☐ yes	☐ no	Heart Disease	☐ yes	☐ no	Stroke	☐ yes	☐ no
Cataracts	☐ yes	☐ no	High Blood Cholesterol Level	☐ yes	☐ no	Thrombophlebitis	☐ yes	☐ no
Chest Pain	☐ yes	☐ no	High Blood Pressure	☐ yes	☐ no	Thyroid Disease	☐ yes	☐ no
Clotting Disorder	☐ yes	☐ no	HIV	☐ yes	☐ no	Tuberculosis	☐ yes	☐ no
Coronary Artery Disease	☐ yes	☐ no	Increased Thirst	☐ yes	☐ no	Ulcers	☐ yes	☐ no
Diabetes Mellitus	☐ yes	☐ no	Increased Urination	☐ yes	☐ no	Urinary Disorder	☐ yes	☐ no
Difficulty in swallowing	☐ yes	☐ no	Kidney Disease	☐ yes	☐ no	Visual Disturbance	☐ yes	☐ no
Dizziness	☐ yes	☐ no	Leg Swelling	☐ yes	☐ no	Weight Gain	☐ yes	☐ no
Double Vision	☐ yes	☐ no	Leg Weakness	☐ yes	☐ no	Weight Loss, Unintentional	☐ yes	☐ no
Emphysema	☐ yes	☐ no	Memory Loss	☐ yes	☐ no			

Other: _____

MEDICAL HISTORY (Continued)

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PATIENT NAME

FAMILY HISTORY

FATHER:

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

MOTHER:

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

SIBLINGS: - How Many _____

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

☐ Alive ☐ Deceased- Age at Death _____ Cause _____

Have you ever been hospitalized for a reason other than surgery? (describe below) ☐ yes ☐ no

REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:

Have you ever had surgery? (describe below) ☐ yes ☐ no

REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:
REASON:	WHEN:

MEDICAL HISTORY (Continued)

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PATIENT NAME

MEDICATIONS

Please list any medications you are currently taking:

MEDICATION NAME	DOSAGE	HOW MANY TIMES PER DAY
1.		
2.		
3.		
4.		
5.		
6.		

HERBAL SUPPLEMENTS OR OVER-THE-COUNTER MEDICINE

Please list any herbal supplements or over-the-counter preparations you are currently taking:

MEDICATION NAME	DOSAGE	HOW MANY TIMES PER DAY
1.		
2.		
3.		
4.		
5.		

Are you presently taking aspirin or have you taken aspirin in the past 7 days? ☐ Yes ☐ No

ALLERGIES

Are you allergic to Latex? ☐ Yes ☐ No

Are you allergic to any medications? (if yes, describe below) ☐ Yes ☐ No

NAME:	REACTION:
NAME:	REACTION:
NAME:	REACTION:

PREFERRED PHARMACY

NAME:	TELEPHONE #:	ADDRESS:

I believe the above information is complete to the best of my knowledge:

Patient Signature: _____ Date: _____

If this form was completed by someone other than the patient, please list name, relationship to the patient and the reason that the patient was unable to complete the form:

HOSPITAL USE ONLY

Reviewed and Discussed

With Patient: _____ Date: _____
SIGNATURE