Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

Department of Neurological Surgery
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Telephone: 212 746-4684
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PATIENT MEDICAL HISTORY

Today's Date: ________________________________

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

DR. J. BOOCKVAR **DR. P. GOBIN** **DR. R HARTL** **DR. M KAPLITT** **DR. S. PANNULLO**

DR. H. RIINA **DR. SCHWARTZ** **DR. M. SOUWEIDANE** **DR. P. STIEG** **DR. M. ZONENSHAYN**

Patient Information

Patient Name: ____
(First) (Middle) (Last)

Home Address: ____
(Street Name and #) (City, State) (Zip Code)

Phone: ______________________________ ______________________________
(Home) (Business)

Demographic Information

Date of Birth:________________ Age: ______________ Sex: _________________

Social Security #: _________________________________ Marital Status: __________________________

Occupation:____

Referral Information

How were you referred to us? WEBSITE INSURANCE FAMILY/FRIEND EMERGENCY ROOM

OTHER __________________________ BRAIN/SPINE ORGANIZATION: __________________________

Referring Physician: ______________________________ Phone #: ____________________________

Address:____

Primary Care Physician: ______________________________ Phone #: _____________________________

Address: ____

Health Information

Reason for today's visit: ____

Other diseases and/or problems:

(1) ____

(2) ____

Lifestyle Information

Do you smoke? ____How many packs a day? ___How many years? ____ Quit? When ___

Do you drink alcohol? ____ How often? ________________How much? _________________

Do you use recreational drugs?____Which Drugs?_____________How often? ____________

Do you exercise regularly? ______ How often? _________What type of exercise? _________

Please indicate if you have any of the following:

Anemia	___Yes ___No	HIV disease	___Yes ___No
Arthritis	___ Yes ___No	Kidney/urinary problems	___Yes ___No
Asthma	___ Yes ___No	Memory loss	___Yes ___No
Bleeding/clotting disorder	___ Yes ___No	Numbness or pain in fingers	___in toes ___arms ___legs
Cancer (Type)	___ Yes ___No	Neuromuscular diseases	___Yes ___No
Chest Pain	___ Yes ___No	Rashes	___Yes ___No
Depression	___ Yes ___No	Ringing in ears	___Yes ___No
Diabetes	___ Yes ___No	Seizures	___Yes ___No
Difficulty speaking	___ Yes ___No	Stomach/intestinal problem	___Yes ___No
Difficulty swallowing	___ Yes ___No	Stroke/CVA	___Yes ___No
Dizziness/fainting	___ Yes ___No	Swelling arms/legs	___Yes ___No
Emphysema	___ Yes ___No	Thrombophlebitis	___Yes ___No
Fevers	___ Yes ___No	Thyroid/Parathyroid Disease	___Yes ___No
Glaucoma/cataracts	___ Yes ___No	Transplant (donor/recipient)	___Yes ___No
Gout	___ Yes ___No	Tuberculosis	___Yes ___No
Headaches	___ Yes ___No	Ulcers (GI/Duodenal)	___Yes ___No
Hearing loss	___ Yes ___No	Unplanned weight loss	___Yes ___No
Heart Disease	___ Yes ___No	Weakness in arms/legs	___Yes ___No
High Cholesterol	___Yes ___No		
High Blood Pressure	___Yes ___No		

Please list any medications you are currently taking:

1. ______________________________________ 2. ______________________________________

3. ______________________________________ 4. ______________________________________

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

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

1. ______________________________________ 2. ______________________________________

3. ______________________________________ 4. ______________________________________

FAMILY HISTORY:

Has anyone in your family had the following?: (**Y / N**)

____ Clotting/bleeding problems ____ Diabetes ____Heart Disease

____ High blood pressure ____High cholesterol ____Stroke/ CVA

MOTHER: ____Alive ____Deceased age at death ______ Cause ______________
FATHER: ____Alive ____Deceased age at death ______ Cause ______________
SIBLINGS: ____How many? ____Alive
____Deceased age at death ______ Cause ______________

____

____

Have you ever been hospitalized for a reason other than surgery?

Reason: ______________________________________ When: ________________

Reason: ______________________________________ When: ________________

Reason: ______________________________________ When: ________________

Have you ever had surgery?

Reason: ______________________________________ When: ________________

Reason: ______________________________________ When: ________________

Reason: ______________________________________ When: ________________

Are you allergic to any medications?

1. ____

2. ____

3. ____

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, relation to the patient and the reason that the patient was unable to complete the form:

____

____

Reviewed and discussed with patient: ___________________________ Date: ____________