



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

Telephone: 212 746-4684
Fax: 212 746-8190

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) _____

Birth History Information

Route of Delivery: VAGINAL C-SECTION

Gestational Age at Delivery: _____

Perinatal Complications: _____

Head Circumference at most recent Pediatrician office visit: _____ Date performed: _____

Please indicate if you have any of the following:

- | | | | |
|----------------------------|--|------------------------------|--|
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney/urinary problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Memory loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding/clotting disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Numbness or pain in fingers | <input type="checkbox"/> in toes <input type="checkbox"/> arms <input type="checkbox"/> legs |
| Cancer (Type) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neuromuscular diseases | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rashes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ringling in ears | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty speaking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/intestinal problem | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty swallowing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke/CVA | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizziness/fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling arms/legs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thrombophlebitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fevers | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid/Parathyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma/cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Transplant (donor/recipient) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers (GI/Duodenal) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | Unplanned weight loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weakness in arms/legs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> 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. _____

