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MEDICAL HISTORY

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

Physician Name: Select from list below

OR Enter Physician Name Below:

[Empty box for selecting physician name]

[Empty box for entering physician name]

PATIENT INFORMATION

PATIENT NAME: (First)		(Middle)	(Last)
ADDRESS: Street Name and #		City, State	Zip Code
TELEPHONE (Home):		TELEPHONE (Business):	

GUARANTOR NAME: (First)		(Middle)	(Last)
RELATIONSHIP OF GUARANTOR TO PATIENT:			
ADDRESS: Street Name and #		City, State	Zip Code
TELEPHONE (Home):	TELEPHONE (Business):	E-MAIL:	

DEMOGRAPHIC INFORMATION

DATE OF BIRTH: (mm/dd/yy)	AGE:	SEX:	NAME OF EMPLOYER:
MARITAL STATUS:	LANGUAGE PREFERENCE:	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)

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 \_\_\_\_\_

Please check (✓) if you have experienced any of the following medical problems:

### SELECT ALL THAT APPLY

- |  |  |
|--|--|
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> HIV Disease   |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Kidney/ Urinary Problem   |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Memory Loss   |
| <input type="checkbox"/> Bleeding/ Clotting Disorder | <input type="checkbox"/> Numbness or Pain in:  |
| <input type="checkbox"/> Cancer (describe below) *   | <input type="checkbox"/> fingers <input type="checkbox"/> toes <input type="checkbox"/> arms <input type="checkbox"/> legs |
| <input type="checkbox"/> Chest Pain                  | <input type="checkbox"/> Neuromuscular Diseases  |
| <input type="checkbox"/> Depression                  | <input type="checkbox"/> Rashes  |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Ringing in Ears   |
| <input type="checkbox"/> Difficulty Speaking         | <input type="checkbox"/> Seizures  |
| <input type="checkbox"/> Difficulty Swallowing       | <input type="checkbox"/> Stomach/ Intestinal Problems  |
| <input type="checkbox"/> Dizziness/ Fainting         | <input type="checkbox"/> Stroke/ CVA   |
| <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Swelling Arms / Legs  |
| <input type="checkbox"/> Fevers                      | <input type="checkbox"/> Thrombophlebitis  |
| <input type="checkbox"/> Glaucoma/ Cataracts         | <input type="checkbox"/> Thyroid/ Parathyroid Disease  |
| <input type="checkbox"/> Gout                        | <input type="checkbox"/> Transplant (donor/recipient)  |
| <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Hearing Loss                | <input type="checkbox"/> Ulcer (GI/Duodenal)   |
| <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Unplanned Weight Loss   |
| <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Weakness in Arms / Legs   |
| <input type="checkbox"/> High Blood Pressure         |  |

\* If applicable - Describe Cancer Type: \_\_\_\_\_

# MEDICAL HISTORY (Continued)

PATIENT NAME: \_\_\_\_\_

## FAMILY HISTORY

Please check (✓) if anyone in your family has had any of the following:

**SELECT ALL THAT APPLY**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Clotting/ Bleeding Problems | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke/ CVA   |

### 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 \_\_\_\_\_

Please check (✓) if you have been hospitalized for a reason other than surgery:

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

Please check (✓) if you have ever had surgery (describe below):

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

# MEDICAL HISTORY (Continued)

PATIENT NAME: \_\_\_\_\_

## MEDICATIONS

Please list any medications you are currently taking (including herbal or over-the-counter preparations)

MEDICATION NAME	DOSAGE	HOW ADMINISTERED *
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

\* Oral, Injection, IV, etc.

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

Please check (✓) if you are allergic to any medications and (describe below):

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

## PREFERRED PHARMACY

NAME:	TELEPHONE #:	ADDRESS:
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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: \_\_\_\_\_

SIGNATURE

Date: \_\_\_\_\_