

**Joan and Sanford I. Weill  
Medical College**

Department of Neurological Surgery  
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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) \_\_\_\_\_

*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. \_\_\_\_\_

