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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. _____

