Stony Brook
Neurosciences Institute

Department of Neurological Surgery
New York Spine & Brain Surgery, UFPC

Dear New Patient,

Welcome to the department of Neurological Surgery at Stony Brook Medical Center. Please take the time to fill out pages 1-5 of the enclosed packet in their entirety, as the provider requires the information from these forms to provide you with the best care possible. Please return all forms to the front desk the day of your visit.

On the day of your visit, it is required that you bring the following to our office:

- The CD or films from any relevant X-ray, MRI or CT scan.
- The reports from any previous nerve testing (EMG/NCS).
- The reports from any prior surgery you have had for this condition (if with another practice).
- Your completed new patient history forms.
- Your insurance information.

If you have not had the chance to fill out the paperwork prior to your appointment – please arrive 30 minutes before your scheduled appointment.

The information from these items will allow the provider to develop a safe and effective treatment plan for your condition.

Thank you for visiting our office and allowing us to become partners in your healthcare.

Sincerely,

New York Spine and Brain Surgery
Department of Neurological Surgery
Stony Brook University Medical Center

Stony Brook Neurosciences Institute

New York Spine and Brain Surgery

Please complete this packet **before** arriving to the office. Thank you!

Your Email Address:

Pharmacy Name: Pharmacy Phone:

Pharmacy Address:

Alternate Pharmacy Name: Alt. Pharmacy Phone:

Alt Pharmacy Address:

PLEASE LIST ALL OF THE FOLLOWING THAT APPLY TO YOU

Primary Care: Phone:

Pediatrician: Phone:

Neurologist: Phone:

Cardiologist: Phone:

Ophthalmologist: Phone:

Orthopedist: Phone:

Pain Management: Phone:

Rheumatologist: Phone:

Other: Phone:

Other: Phone

List any **Allergies** to medications, foods, shellfish, iodine, contrast dye, etc. Please explain the reaction (mild moderate or severe): ***IF NONE WRITE NKA IN FIRST BOX***

Allergy	Mild, Moderate, or Severe?	Allergy	Mild, Moderate, or Severe?	Allergy	Mild, Moderate, or Severe?

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Past Medical History: Please mark Y or N if you have had any of the following conditions:

Angina		Anxiety Disorder		Asthma/COPD Emphysema		Bleeding Disorder	
Cancer (If "Y" Describe Below)		Congestive Heart Failure		Diabetes		Depression	
Epilepsy/Seizures		GERD/Reflux/Ulcers		Heart Attack		High Cholesterol	
High Blood Pressure		Kidney Disease		Liver Disease		Multiple Sclerosis	
Neuropathy		Osteoarthritis		Osteoporosis		Pacemaker/Defibrillator	
Rheumatoid Arthritis		Stroke		Thyroid Disorder		Other (List Below)	

Please clarify, if necessary, any of the above selections:

Past Surgical History: Have you had previous surgery? **Y** **N** If "Y" please elaborate below.

Type of Surgery	Approximate Date	Surgeon	Problems with Anesthesia? Describe.

Family Medical History: Please list any medical conditions and/or cause of death for members of your family:

Parents:

Siblings:

Social History: Do you use tobacco? **Y** **N** Have you ever used tobacco? **Y** **N** Do you drink alcohol? **Y** **N**

Do you have a history of substance abuse? **Y** **N**

Medications: Please list all Prescription, Over-the-counter, Vitamins, Supplements and Herbal remedies you take.
If you have a list please write SEE ATTACHED in first box and bring the list to your visit.

Drug / Dose	Frequency	Drug / Dose	Frequency

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New Patient History Form

New York Spine and Brain Surgery

Please answer the questions as thoroughly as possible. If a question does not apply to you please write N/A.

Patient name: Gender: SSN:

Home Phone:( ) Work :( ) Cell: ( )

Street Address: City:

State: Zip: Date of Birth: Age:

Marital Status: Occupation: Currently Employed?

Primary Complaint: What are you here to see the doctor for today?

When did it begin?

Was there a cause for this injury (accident, fall, moved heavy object, etc)?

When is the problem worse (specific activities, positions, time of day, etc)?

When is the problem better (specific activities, positions, time of day, etc)?

What hobbies/chores/activities are you unable to do as a result of this problem?

Is this problem interfering with your ability to fall or stay asleep?

Are you presently not working as a result of this problem?

Are you presently involved in any litigation related to this problem?

Have you had any prior studies within the last year for this problem? Please write the most recent dates for each:

STUDY	DATE(s):	BODY PART STUDIED:	DO YOU HAVE REPORTS?
XRAY			
MRI			
CT SCAN			
EMG			
Myelogram			
Bone Density			
Other			

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Have you had any of the following treatments for this problem? Please write the most recent dates for each:

TREATMENT:	DATE(s):	PROVIDERS:	EFFECTIVENESS:
Physical Therapy			
Home Exercise Program			
Chiropractor			
Acupuncture			
Epidural Injections			
Trigger Point Injections			
Facet Injections			
Massage			
Medications			
Other			
Other			
Other			

Miscellaneous History: Are you **RIGHT** or **LEFT** handed?

Review of Systems: Please check if you experience any of the following.

Difficulty Sleeping		Fatigue		>20 lbs weight gain or loss	
Abdominal Pain		Nausea / Vomiting		Heartburn	
Constipation		Diarrhea		Bowel Incontinence	
Painful Urination		Urgent / Frequent Urination		Urinary Incontinence	
Wear Glasses / Contacts		Blurry / Double Vision		Heat or Cold Intolerance	
Unusual Hair Growth		Unusual Hair Loss		Hearing Loss	
Ringing in Ears		Dentures		Sore Throat	
Seasonal Allergies / Hay Fever		Chest Pain		Shortness of Breath	
Heart Palpitations		Coughing		Wheezing	
Joint Pains		Muscle Aches		Headaches	
Rash		Hives		Anxiety	
Depression		Fainting		Numbness	
Tingling		Weakness		Anemia	
Easy Bruising		Prolonged Bleeding		Nosebleeds	
Bleeding Gums		Tired of Paperwork			

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Name: _____ Date of Birth:_____

Today's Date:_____ MRN(Office Use):_____ P: 5/5

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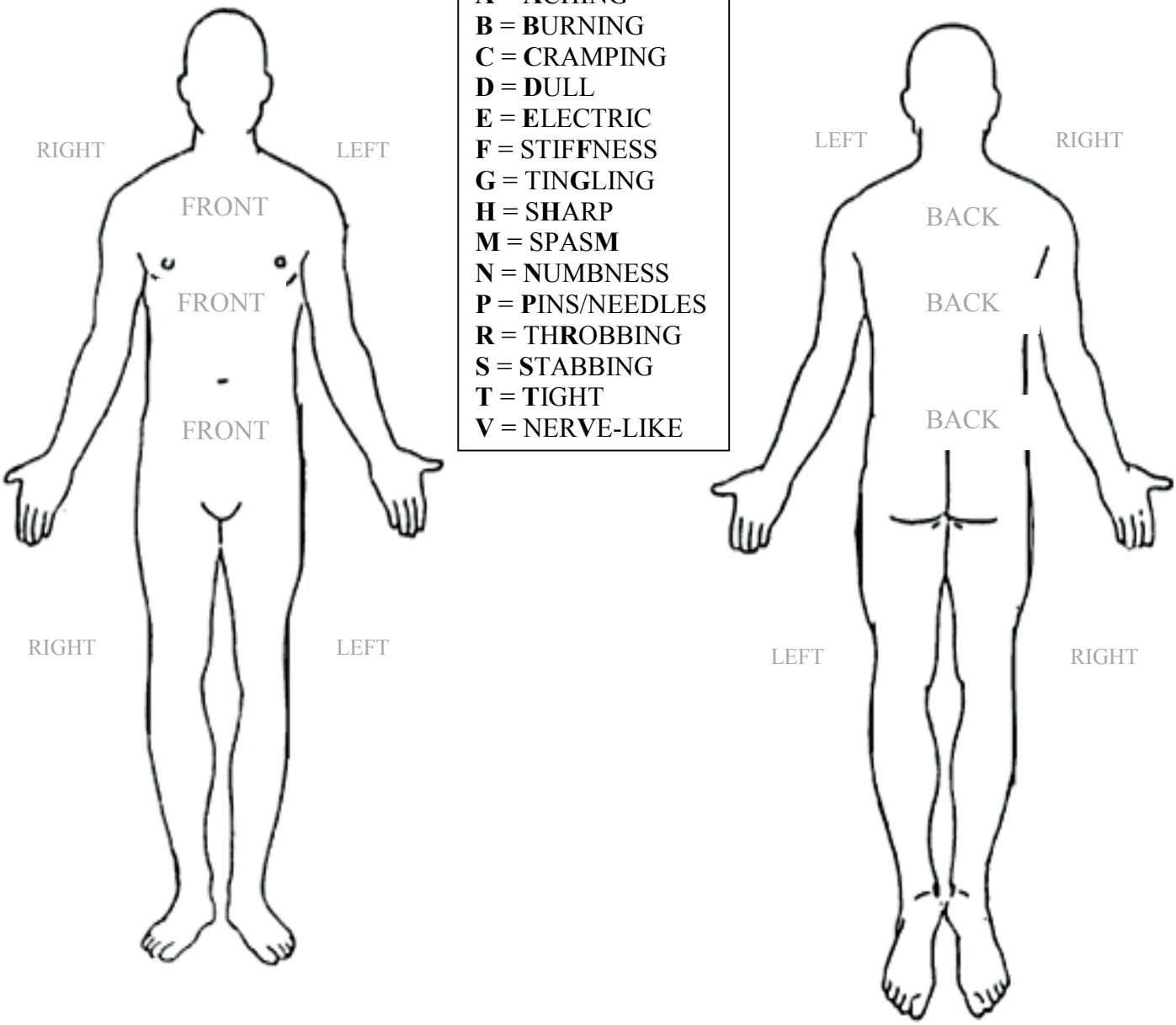
Please indicate the location and type of pain you experience on the diagram below, using the appropriate letter(s) from the chart below.

A = **A**CHING
B = **B**URNING
C = **C**RAMPING
D = **D**ULL
E = **E**LECTRIC
F = STIF**F**NESS
G = TIN**G**LING
H = S**H**ARP
M = SPAS**M**
N = **N**UMBNESS
P = **P**INS/NEEDLES
R = TH**R**OBBING
S = **S**TABBING
T = **T**IGHT
V = NER**V**E-LIKE



NO PAIN |---------|---------|---------|---------|---------|---------|---------|---------|---------|---------| WORST PAIN

I have reviewed the above 5-page packet and believe it is complete to the best of my knowledge.

PATIENT Signature: _____ Date: _____

If this packet was completed by someone other than the patient, please list name, relation to the patient and the reason the patient was unable to complete the packet:

I have reviewed and discussed the contents of this 5-page packet with the patient.

Provider Signature: _____ Date: _____