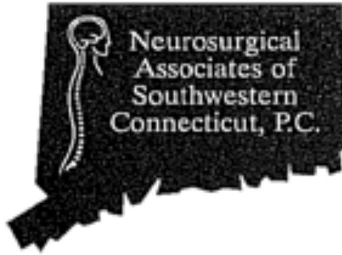
S.J. Shahid, M.D.
Diplomate, American Board of Neurological Surgery
Ramon A. Batson, M.D.
Diplomate, American Board of Neurological Surgery
Scott P. Sanderson, M.D.
Assistant Clinical Professor of Neurosurgery, NYU Medical Center
Alicia Potes, PA-C
Kent J. Kilbourn, PA-C



148 East Avenue
Norwalk, CT 06851-5724
Phone (203) 853-0003
Fax (203) 838-5423

67 Sand Pit Road
Danbury, CT 06810-4032
Phone (203) 792-2003
Fax (203) 792-8193

New Patient History Form

Date:________________

Patient Name:___________________________________Date of Birth:______________

Chief Complaint

Reason for initial visit: ____

Current problem is the result of a: (*Check all that apply*)
____Car Accident____Work Accident____Accident____Other

Past History

Please list any prior major illnesses and/or injuries:
____
____
____
____

Surgeries/Hospitalizations   Year   Complications
____
____
____

List all Allergies (including drugs, food, other [latex]):
____
____
____

Have you ever had problems with anesthesia?_____Yes   ______No

Current Medication(s)   Dose   Frequency
____
____
____
____
____
____

Family History

Family Member	Alive	Deceased	Age	Health status/cause of death
Grandmother (mom's)	A	D		______________________________
Grandfather (mom's)	A	D		______________________________
Grandmother (dad's)	A	D		______________________________
Grandfather (dad's)	A	D		______________________________
Mother	A	D		______________________________
Father	A	D		______________________________
Sister/Brother	A	D		______________________________
Sister/Brother	A	D		______________________________
Sister/Brother	A	D		______________________________
Sister/Brother	A	D		______________________________

Social History

Occupation: ____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed

Do you have children? ____ Yes ____ No How many? ____________________

Do you live alone? ____ Yes ____ No Who lives with you? ____________

Do you smoke? ____ Yes, I've smoked ___ packs of cigarettes per day for __ years.
____ Yes, I smoke cigars or a pipe.
____ No, I have never smoked.
____ No, I quit ___ years ago. At that time I was smoking __ packs per day for __ years.

Do you drink alcohol? ____ No, never (or rarely) ____ No, but I used to.
____ Yes ____ Daily ____ 1 or more times per week ____1 or more times a month

Are you at risk for AIDS (e.g. sexual orientation, drug abuse, previous blood transfusion)?
____ No ____ Yes, please explain: ____

Review of Systems

Constitutional	*Circle One*	
Fever	Yes	No
Weight Loss	Yes	No
Excessive Fatigue	Yes	No
Night Sweats	Yes	No

Eyes		
Wear Glasses -- Date of last exam____________	Yes	No
Infections	Yes	No
Injuries	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No

Ears, Nose, Throat and Mouth		
Wearing Hearing Aids -- Date of last exam________	Yes	No
Hearing Loss	Yes	No
Ear Pain	Yes	No
Ear Infections	Yes	No
Ringing in Ears *Circle:* Left Right Both	Yes	No
Balance Disturbance (e.g. Vertigo, Spinning)	Yes	No
Nose Bleeds	Yes	No
Nasal Congestion	Yes	No
Nasal Drainage -- Amount _________ Color ________	Yes	No
Inability to Smell	Yes	No
Sinus Problems	Yes	No
Sinus Headaches	Yes	No
Sore Throats	Yes	No
Mouth Sores	Yes	No

Cardiovascular		
Chest Pain or Angina -- Date of Last EKG: ___________	Yes	No
High Blood Pressure	Yes	No
Irregular Pulse	Yes	No
Heart Murmur	Yes	No
High Cholesterol	Yes	No
Swelling in Feet or Hands	Yes	No
Leg Pain while walking	Yes	No

Respiratory		
Asthma	Yes	No
Chronic Cough	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Lung Cancer	Yes	No
Blood Sputum	Yes	No

Date of Last Chest X-ray: __________________

Gastrointestinal

Indigestion or Pain with Eating	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Blood in your vomit	Yes	No
Liver Disease	Yes	No
Jaundice	Yes	No
Abdominal Pain	Yes	No
Change in your Bowel Habits	Yes	No
Colon Cancer	Yes	No

Genitourinary

Urinary Tract Infection	Yes	No
Painful Urination	Yes	No
Blood in your Urine	Yes	No
Difficulty Starting or Stopping Stream	Yes	No
Incontinence	Yes	No
Kidney Stones	Yes	No
Prostate Cancer (males)	Yes	No
Endometriosis (females)	Yes	No
Uterine or Cervical Cancer (females)	Yes	No

Musculoskeletal

Broken Bones: List ______________________________	Yes	No
Arm or Leg Weakness	Yes	No
Back Pain	Yes	No
Arm or Leg Pain	Yes	No
Joint Pain or Swelling	Yes	No
Arthritis	Yes	No

Integumentary

Skin Disease	Yes	No
Skin Cancer	Yes	No
Breast Pain, Tenderness or Swelling (female)	Yes	No
Nipple Discharge (female)	Yes	No

Date and Result of Last Mammogram (female) ____________________

Neurological

Fainting Spells or "Blacking Out"	Yes	No
Seizures	Yes	No
Problems with your Memory	Yes	No
Disorientation	Yes	No
Inability to Concentrate	Yes	No

Neurological (*continued)*

Double or Blurred Vision	Yes	No
Face Weakness	Yes	No
Coordination in Arm and/or Legs	Yes	No

Psychiatric

Anxiety	Yes	No
Depression	Yes	No

Other Psychiatric Disorder/Treatment: ____________________________

Endocrine

Diabetes	Yes	No
Thyroid Disease	Yes	No
Increased Appetite	Yes	No
Excessive Thirst or Urination	Yes	No
Hormone Problems	Yes	No

Hematologic/Lymphatic

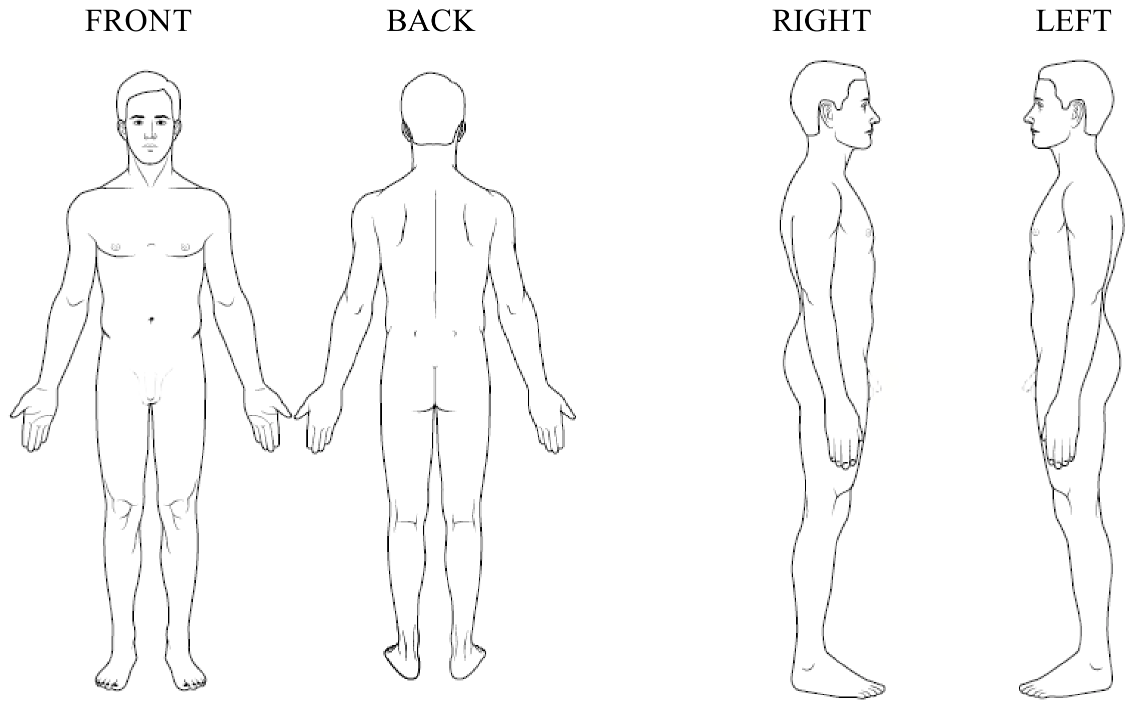
Anemia	Yes	No
Hemophilia	Yes	No
Persistent Swollen Glands or Lymph Nodes	Yes	No
Blood Transfusion: If yes, when: _________________	Yes	No

Allergic/Immunologic

Food Allergies	Yes	No
Inhalant (nasal) Allergies	Yes	No
Immunologic Disorders	Yes	No

(Continue to next page)

Pain Drawing -- Please fill this out carefully. Mark the area on your body where you feel the described sensation. Use the appropriate symbol. Mark the areas of radiating pain and include all affected areas.



Numbness -- **N**   Burning Pain - **B**   Aching Pain – **A**   Pins & Needles -- **P**
Stabbing Pain – **S**

The above information is accurate to the best of my knowledge.

________________________   ___________________
Patient Signature   Date

I have reviewed the above information with the patient.

________________________   ___________________
Physician Signature   Date