



**Center for Neuromodulation
 Department of Neurosurgery
 530 First Avenue, Skirball 8S
 New York, NY 10016**

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INITIAL INTAKE FORM

Name _____	Date ___/___/___
Date of Birth ___/___/___	Age _____
Referring Doctor/Source _____	Tel. Number _____
Primary Care Doctor _____	Tel. Number _____

Explain why you are seeing Dr. Alon Mogilner (neurosurgeon):

Your medical history (please check and describe if appropriate):

Condition		Details
Heart Disease		
High Blood Pressure		
Asthma		
High Cholesterol		
Parkinson's Disease		
Tremor		
Emphysema		
Bronchitis		
Cancer		
Epilepsy/Seizures		
Stroke		
Ulcers		
GI Reflux		
Hepatitis		

Kidney Stones		
Kidney/Renal problems		
Prostate Problems		
Endocrine/Hormonal Problems		
Diabetes		
Other:		

**Please List all of your current medications including herbs and supplements:
(or attach a copy)**

Medication	Dose	Times per day

Surgical History

Please list all the surgeries that you have had and the approximate dates they were done:

Surgeries	Dates



Please check if you take any of the following medications:

Aspirin _____
Plavix _____
Coumadin _____
Any other blood thinner: _____

Do you have a bleeding disorder? ___ Yes ___ No
If “yes”, please describe:

Do you have any allergies to any medications? Yes___ No___
If you answered “Yes”, please write down the name of the medication and the allergic reaction:

Medication	Allergic Reaction

Please record any other non-medication allergies you have (food, seasonal allergies, etc).

Are you : (please check) ___right handed ___left handed ___ambidextrous

Family History (please check if present in any family members):

High Blood Pressure _____ Cardiac Disease _____
Parkinson’s Disease _____ Pulmonary Disease _____
Other:



Social History

Marital status: _____
 Number of Children: _____
 Whom do you live with?: _____
 Do you smoke cigarettes? _____
 For how long have you smoked? _____
 How many packs per day do/did you smoke? _____
 Have you tried or thought of quitting? _____
 Have you abused substances? _____
 Do you drink alcohol? _____
 How much? _____
 Do you use street drugs? _____
 Have you been treated in a drug rehab? _____
 Have you had any sexually transmitted diseases? _____
 Are you employed? _____
 What's your occupation? _____
 Date of your last employment? _____

Are you being treated for depression? _____ Yes _____ No
 Who is your primary care physician? _____

Review of Systems Please circle all that apply to you:

General	Fever Malaise Fatigue Generalized weakness Chronic Pain
Eyes	Blurriness of vision Pain or pressure in the eyes Blindness Cataracts Glaucoma Double vision
Eyes/ears/nose/mouth	Nose bleeding runny nose difficulty hearing ringing in the ears ulcers in the mouth difficulty chewing difficulty or pain when swallowing Ear infection Polyps Sinusitis
Heart	Chest pain angina irregular heartbeat fainting stroke Heart attack Pacemaker
Lungs	Difficulty breathing shortness of breath coughing wheezing Asthma Emphysema
Gastrointestinal	Loss of appetite vomiting nausea constipation diarrhea bleeding or blood in the stool loss of bowel control
Genitourinary	Difficulty urinating painful urination urinary frequency blood in the urine frequency at night Stress incontinence Loss of bladder control Enlarged prostate or BPH
Musculoskeletal	Arthritic pain stiffness flaccidity contractures rigidity joint pains muscle aches/pains fractures osteoporosis osteoarthritis Gout
Skin	Rash Itching Keloids Pressure ulcers wounds Melanoma Basal cell carcinoma Lumps warts moles
Neurological	Seizures Epilepsy Numbness or tingling sensations headaches dizziness Balance problems gait disorder
Psychiatric	Depression Sadness Mania Withdrawals Drug addiction suicidal thoughts Schizophrenia

Endocrine	Palpitations weight loss intolerance to cold or heat urinating a lot Loss or thinning of hair insomnia rapid heart rate insomnia
Blood and Lymphatics	Bleeding or bruising Swollen glands
Allergic / Immunologic	Drug /food/latex allergy arthritis prior transplant hay fever Lupus Gets sick easily allergic rhinitis

PLEASE SIGN AND DATE:

Patient's Signature _____ Date ___/___/___

Height ___ ft. ___ in. Weight ___ lbs.

BP ___/___ HR _____ RR _____ Temp. _____

