Weill Cornell Medical College

NewYork-Presbyterian
Lower Manhattan Hospital

New Patient Medical History

Please Note: All information is confidential and will become part of your medical record
Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. **PLEASE PRINT CLEARLY**.

Patient Name:		Date of Visit:
Date of Birth:	Age:	***Home Phone:*** ***Other Phone:***
Preferred email:		Social Security Number:
Address:		***Emergency Contact (Name and Number):***
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Domestic Partner		Spouse/Significant Other:
Employer:		Occupation:
PRIMARY INSURANCE CARRIER:		**INSURANCE ID #:**
Does your insurance plan require referrals for specialty visits? ❑ Yes ❑ No		If YES, do you have a referral for today's visit? ❑ Yes ❑ No

Physician and Pharmacy Information	
Primary Care Provider (Name/Phone/Fax Number):	**Preferred Pharmacy** (Name/Phone/Fax Number):
Referring Physician (Name/Phone/Fax Number): ❑ Same as PCP	**Other Physician to send records to** (Name/Phone/Fax Number):
Specialty:	Specialty:
Other Physician to send records to (Name/Phone/Fax Number):	**Other Physician to send records to** (Name/Phone/Fax Number):
Specialty:	Specialty:

Reason/s For Visit:

Medical History		
Please include all medical problems even if not relevant to this visit. If no medical problems, write none.		
Current or Past Medical Problems	**Dates**	**Reasons**

Hospitalizations/Surgeries	**Dates**	**Reason**

Allergies (Medication, Food, Cosmetics, Etc.)	Cause/Nature of Reaction

Medications/Supplements	Dosage/Frequency	Condition/Reason

Family and Social History			
Family History: **Mother**	Family History: **Father**	Family History: **Siblings**	Family History: **Children**
❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:

Do you drink **alcohol**?	Do you **smoke**?	Do you use recreational **drugs**?
❑ Never ❑ Yes. I drink ❑ wine ❑ beer ❑ liquor ❑ I have _____ drink(s) per week ❑ I used to drink but quit in _____ (year)	❑ I never smoked ❑ Yes. I smoke ❑ cigarettes ❑ cigars ❑ pipes. ❑ I currently smoke and I don't want to quit ❑ I currently smoke but I'm ready to quit. ❑ I smoke _____ pack(s) per day for _____ years ❑ I used to smoke but quit in _____(year) ❑ I use chewing or smokeless tobacco	❑ Never ❑ No, but I have used _____ ❑ Yes, I use _____

Do you eat or drink foods containing **caffeine?**	Have you taken any **aspirin, Advil, Nuprin** (NSAIDs) in the last 7 days?
❑ Yes ❑ No	❑ Yes (if so, what medication? _____) ❑ No

Do you **exercise**?	**If yes, how often and what type?**
❑ Yes ❑ No	

Date of most recent flu shot (age 6 months+):	Date of most recent pneumonia shot (age 65+):

How did you hear about us?

❑ Physician ❑ Family/Friend ❑ Internet ❑ Health Plan ❑ Advertisement ❑ Referral Service ❑ Weill Cornell Connect ❑ Int'l Office

The information is accurate and complete to the best of my knowledge.
I will not hold the physician or his staff responsible for any error or omission that I may have made completing this form.

Patient Signature: Name of person completing form (if not patient): Signature: Today's Date:	Physician Signature: Today's Date:

Review of Systems

Please check 'YES' or 'NO' for EACH item

Constitutional
❑ Normal
Y N
❑ ❑ Fever
❑ ❑ Chills
❑ ❑ Night sweats
❑ ❑ Weight loss/gain
❑ ❑ Sleep disturbance
❑ ❑ Fatigue
❑ ❑ Poor appetite

Eyes
❑ Normal
Y N
❑ ❑ Contact lenses or glasses
Type: _____
❑ ❑ Blurry vision
❑ ❑ Glaucoma
❑ ❑ Cataracts
❑ ❑ Retinal detachment
❑ ❑ Macular degeneration
❑ ❑ Blindness
❑ ❑ Redness
❑ ❑ Tearing
❑ ❑ Dryness
❑ ❑ Double Vision
❑ ❑ Discharge
❑ ❑ Pain

Ear
❑ Normal
Y N
❑ ❑ Hearing loss
❑ ❑ Hearing aids
❑ ❑ Wax
❑ ❑ Ear pain
❑ ❑ Ringing/noise/tinnitus
❑ ❑ Previous ear surgery
❑ ❑ Loud noise exposure

Respiratory
❑ Normal
Y N
❑ ❑ Asthma
❑ ❑ Emphysema/COPD
❑ ❑ Bronchitis
❑ ❑ Pneumonia
❑ ❑ Aspiration
❑ ❑ Tracheotomy
❑ ❑ Tuberculosis
❑ ❑ Coughing blood
❑ ❑ Shortness of breath
❑ ❑ Wheezing
❑ ❑ Cough over 3 months
❑ ❑ Pulmonary embolus

Nose
❑ Normal
Y N
❑ ❑ Congestion
❑ ❑ Mucus
❑ ❑ Post nasal drip
❑ ❑ Sinus infection
❑ ❑ Sinus headaches
❑ ❑ Nose Bleeds

Allergy
❑ Normal
Y N
❑ ❑ Sneezing
❑ ❑ Runny Nose
❑ ❑ Itchy ears, eyes, or nose
❑ ❑ Transplant
❑ ❑ Hives

Throat
❑ Normal
Y N
❑ ❑ Voice problems
❑ ❑ Swallowing problems
❑ ❑ Throat Pain
❑ ❑ Phlegm
❑ ❑ Feeling of something stuck
❑ ❑ Tonsil infections/problems

Sleep
❑ Normal
Y N
❑ ❑ Snoring
❑ ❑ Sleep Apnea
❑ ❑ CPAP/BiPAP/AutoPAP
❑ ❑ Insomnia
❑ ❑ Choking/Gasping
❑ ❑ Restless leg
❑ ❑ Daytime sleepiness

Gastrointestinal
❑ Normal
Y N
❑ ❑ Diarrhea
❑ ❑ Constipation
❑ ❑ Blood in stool
❑ ❑ Vomiting/nausea
❑ ❑ Ascites
❑ ❑ Heartburn/acid reflux
❑ ❑ Abdominal pain
❑ ❑ Ulcers
❑ ❑ Diverticulitis
❑ ❑ IBD
❑ ❑ Hepatitis
❑ ❑ Gallstones
❑ ❑ Pancreatitis
❑ ❑ Jaundice
❑ ❑ Cirrhosis

Endocrine
❑ Normal
Y N
❑ ❑ Diabetes
❑ ❑ Thyroid problems
❑ ❑ Autoimmune disease
Type: _____
❑ ❑ Immune deficiency
❑ ❑ Excessive thirst
❑ ❑ Swollen lymph nodes
❑ ❑ Cold/heat intolerance
❑ ❑ Gout

Neurologic/Neuromuscular
❑ Normal
Y N
❑ ❑ Headaches/migraines
❑ ❑ Encephalopathy
❑ ❑ Seizures
❑ ❑ Tremors
❑ ❑ Numbness
❑ ❑ Stroke
❑ ❑ Imbalance/vertigo
❑ ❑ Lightheaded/fainting
❑ ❑ Memory loss
❑ ❑ Unexplained weakness

Hematologic
❑ Normal
Y N
❑ ❑ Bruise easily
❑ ❑ Anemia
❑ ❑ Leukemia/Lymphoma
❑ ❑ Blood clots
❑ ❑ Bleeding disorders
❑ ❑ History of radiation

Oral/Dental
❑ Normal
Y N
❑ ❑ Dentures/implants
❑ ❑ Temporomandibular joint
❑ ❑ Teeth clenching/grinding
❑ ❑ Tongue problems
❑ ❑ Mouth lesions

Genitourinary
❑ Normal
Y N
❑ ❑ Frequent urination
❑ ❑ Prostate problems
❑ ❑ Urine/bladder infections
❑ ❑ Yeast infections
❑ ❑ Incontinence
❑ ❑ Kidney problems/stones
❑ ❑ Dialysis
❑ ❑ Transplant

Skin
❑ Normal
Y N
❑ ❑ Past skin cancer
Type: _____
❑ ❑ Skin biopsy
Site: _____
❑ ❑ Eczema
❑ ❑ Rash or skin sensitivity
❑ ❑ Abnormal skin moles
❑ ❑ History of skin disease
❑ ❑ Hair loss/growth
❑ ❑ Itching
❑ ❑ Keloid scars

Musculoskeletal
❑ Normal
Y N
❑ ❑ Neck pain
❑ ❑ Arthritis
❑ ❑ Back pain/spinal problems
❑ ❑ Fractures
❑ ❑ Muscle pain
❑ ❑ Swelling
❑ ❑ Joint/bone pain

Cardiovascular
❑ Normal
Y N
❑ ❑ Heart attack
❑ ❑ High blood pressure
❑ ❑ High cholesterol
❑ ❑ Stents
❑ ❑ Coronary artery disease
❑ ❑ Irregular heart beat
❑ ❑ Chest pains
❑ ❑ Leg swelling
❑ ❑ Pacemaker/defibrillator

Psychiatric
❑ Normal
Y N
❑ ❑ Anxiety
❑ ❑ Depression
❑ ❑ Bi-polar
❑ ❑ Psychosis

Men's/Women's Health
❑ Normal
Y N
❑ ❑ Sexual problems
❑ ❑ Genital lesions
❑ ❑ Enlarged prostate (BPH)
❑ ❑ Abnormal discharge
❑ ❑ Cancer
Type: _____

Any other comments/problems/concerns:

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Financial Policy

Thank you for choosing Weill Cornell Physicians for your health-care needs.

The following is our payment policy which we require you to read and sign prior your visit(s).

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. To ensure that we have accurate information to process your claim, we will make a copy of your medical insurance and/or Medicare card at the time of your appointment.

You are required to inform us immediately of any changes in demographic information or medical insurance information. Patients without medical insurance are required to pay in full at time of service.

We understand that financial hardships may affect your ability to pay in full. We will always do everything we can to work with you. Please ask to speak to our Site Manager to discuss a satisfactory arrangement.

Participating Plans
You must present your insurance card, and if applicable, your insurance referral form, at every visit. We will submit bills directly to your insurance company for payment on your behalf. Patients without insurance cards or proper referrals will be asked for full payment at time of service. All co-pays, deductibles and non-covered services will be collected at time of service.

Non-Participating Plans
If your provider does not participate in your insurance plan, you are responsible for payment of all charges at the time of service. We can submit the claim directly to your carrier or a claim can be mailed to you.

Payment in full is due at the time of service for all non-medically necessary services and/or cosmetic services.

Usual and Customary Rates
Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for your patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment
For your convenience, the following payment methods are accepted:
Cash, personal check, Visa, MasterCard, American Express, Discover

I have read the policy, I understand and agree to it.

_____ _____

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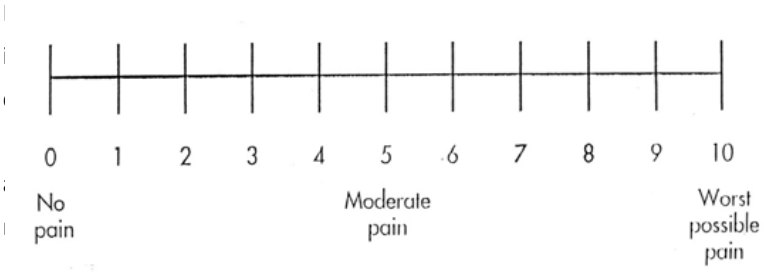
BRAIN AND SPINE CENTER NEW PATIENT QUESTIONNAIRE

New Patient Medical History

On the diagram below, write X to indicate the severity of pain you are having right now. Write L to indicate least pain. Write W, to indicate worst pain.



accident or other event precipitate your pain? ☐YES ☐NO If yes, please describe:

Were you injured at work? ☐YES ☐ NO

Are you filing for Worker's Comp? ☐ YES ☐ NO

Are you currently involved in litigation? ☐YES ☐ NO

When did the pain start?_____

Frequency of pain:	**Duration of pain:**
times a day	seconds
times a week	minutes
times a month	hours

Do you experience…

☐Weakness ☐Numbness ☐Tingling

When is the pain worst?

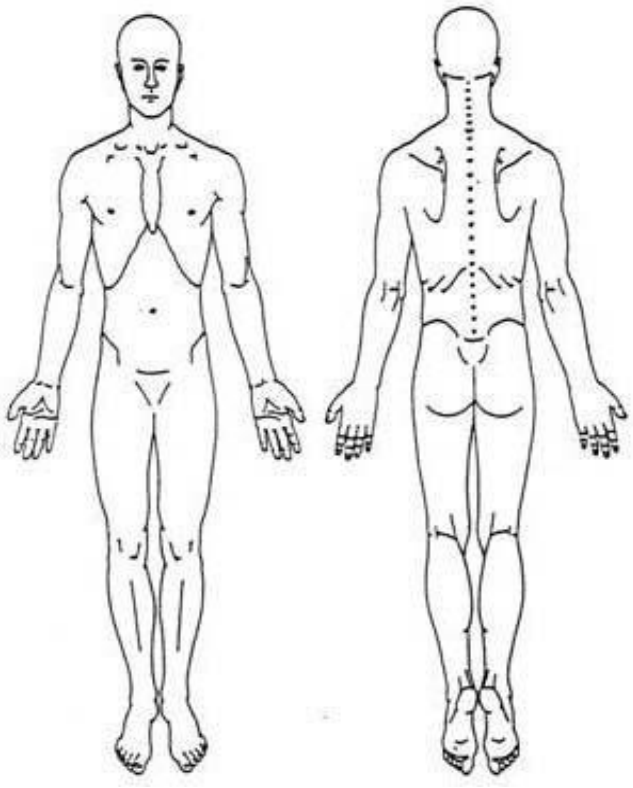
☐Morning ☐Afternoon ☐Evening ☐Night

☐Changing positions

Describe pain:

☐Burning ☐Sharp ☐Shooting
☐Dull ☐Numbness ☐Electrical
☐Throbbing ☐Aching ☐Cramps
☐Gripping ☐Pins/Needles

On the drawings below, shade the location of pain. Indicate the worst area with an X.



On a scale from 0 to 10, please circle your level of pain or discomfort, with **0 being none and 10 being unbearable** for the following areas:

Neck Pain	0	1	2	3	4	5	6	7	8	9	10
Left Shoulder Pain	0	1	2	3	4	5	6	7	8	9	10
Right Shoulder Pain	0	1	2	3	4	5	6	7	8	9	10
Left Arm Pain	0	1	2	3	4	5	6	7	8	9	10
Right Arm Pain	0	1	2	3	4	5	6	7	8	9	10
Back Pain	0	1	2	3	4	5	6	7	8	9	10
Left Hip/Buttock Pain	0	1	2	3	4	5	6	7	8	9	10
Right Hip/Buttock Pain	0	1	2	3	4	5	6	7	8	9	10
Left Leg Pain	0	1	2	3	4	5	6	7	8	9	10
Right Leg Pain	0	1	2	3	4	5	6	7	8	9	10

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Name: _____ **Date:** _____

Pain interferes with (check all that apply):

☐Appetite ☐Sleep ☐Sex

☐Self-care ☐Hobbies ☐Job performance

☐Social Life ☐Exercise ☐Travelling

☐Lifting ☐Shopping ☐House chores

☐Driving ☐Cooking

What makes pain better?

_____

_____

What makes pain worse?

_____

_____

How far can you walk? Do you require assistance?

_____

_____

Below, indicate past treatments for pain:

Type	Date
Nerve Blocks	
Steroid Injections	
Physical Therapy	
Psychotherapy	
Acupuncture	
Surgery	
Chiropractic	
Failed Meds	
Other	

Have you had any of the following imaging studies?

☐Xray ☐CT Scan ☐MRI ☐Bone Scan ☐EMG

☐Other _____

If yes, please list dates of scans: _____

Females: LMP: _____ Please notify MD/NP/RN/PA, if you are pregnant. ☐Yes ☐No

Cancer: ☐ Yes ☐No If yes, type: _____ Chemo: ☐Yes ☐No Radiation: ☐Yes ☐No

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

Form completely by: _____ Date _____

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Weill Cornell Pain Medicine
PAIN MEDICINE PRACTICE CONTROLLED DRUG PRESCRIPTION AGREEMENT

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. These medications are regulated by the United States Food and Drug Administration, New York State, and Drug Enforcement Administration.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain. Because these drugs have potential for abuse, misuse, or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. If you are prescribed opioids from the pain clinic, future prescriptions must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. However, if you reach a "Stable" dose of medication that allows a satisfactory balance of functional and pain improvement and minimizes side effects, you may be transferred back to your primary care provider for future prescriptions. Your Pain Physician will coordinate this. Multiple sources can lead to untoward drug interactions or poor coordination of treatment.

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed.

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

5. You may not share, sell, or permit others to have access to these medications.

6. These drugs should be taken as prescribed including dose and frequency and may not be altered without direct approval from your Physician. Also they should not be stopped abruptly, as a withdrawal syndrome may develop.

7. Unannounced urine, saliva, or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances will be noted in your medical record and may prompt referral for assessment for addictive disorder along with discontinuation of your opioid prescriptions.

8. These medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

9. You may be asked to bring original containers of prescribed medications to your follow up visit.

10. You will refrain from use of illegal drugs or alcohol with the use of these medications.

11. You understand that you may place yourself or others at risk if you drive or operate heavy machinery.

12. You may be asked to participate in psychological or psychiatric assessments as part of your treatment in order to best monitor use of these medications.

13. Medications may not be replaced if they are lost or are destroyed. If your medication has been stolen and you complete a police report along with a letter recounting the event regarding the theft, an exception may be made. Only one lost prescription or medication will be replaced in a given calendar year.

14. Early refills will generally not be given. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends as requests will not be honored.

15. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

16. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribing by this physician or referral for further specialty assessment.

17. As per New York State Law, your doctor will check the State's Prescription Monitoring program to verify your opioid prescription history.

18. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit. You agree that these medications may stop being prescribed if you:
    A. Don't show improvement in function
    B. Behave in a way not consistent with the above responsibilities.
    C. Give away, sell, or misuse the opioids
    D. Develop an addiction problem from opioids
    E. Don't cooperate with responsibilities listed above, or refuse drug screening.
    F. Experience a serious adverse outcome to treatment.
    G. Don't keep regular follow up appointments

19. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such explanation.

20. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

_____ _____

Patient's Signature Print Name MD/NP Signature Date

Weill Cornell Pain Medicine; *Controlled Substances (Opioids) Safety Guidelines*

Possible Side Effects of your opioids include but are not limited to:
Confusion, Nausea, Vomiting, Constipation, Dry Mouth, Low Testosterone, Central Sleep Apnea, Opioid Use Disorder and Addiction, Aggravation or Depression, Breathing too slowly or overdose causing you to stop breathing.

You may also develop:
Psychological Dependence—it is possible stopping the opioids may cause you to miss or crave the drug
Tolerance—you may need more and more drug to get the same effect.
Addiction---Patients may develop addiction to opioids
Problems with pregnancy—if you are pregnant or contemplating pregnancy, discuss with your provider.

Stopping opioids abruptly may cause the following due to physical dependence:
Runny nose, abdominal cramping, diarrhea, sweating, nervousness, difficulty sleeping, rapid heart rate, goose bumps
It is recommended you keep a diary of the pain medications you are taking including doses, time you take the medication, time of day, their effectiveness, and any side effects.

Please call 646-962-7246 with any questions or concerns.
For medical emergencies please dial 911, or proceed to your nearest emergency room.

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Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
		TOTAL	_____	_____

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk $\geq$8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine*. 2005;6(6):432-442. Used with permission.