Appointment Date & Time:

INITIAL CONSULTATION CHECKLIST

To better assist you, please use the checklist below:

1. **New Patient form**. Please print, fill out, and bring at the time of your consultation

2. M**edication list.** Please bring a neatly list of all your medications.

3. **Referral Form.** If required by your insurance company, bring a referral form from your Primary Care Physician (PCP).

4. **MRI and/or CT scans.** Bring the actual films or CD and the reports of all your brain or spine imaging studies<u>. Please note that the doctor will NOT see you unless you have the actual FILMS, not just the reports</u>.

5. **Pathology report.** If you had a brain or spine biopsy or surgeries please bring the pathology report.

6. S**urgery report**. If you had a brain or spine biopsy or surgeries please bring the surgery report.

7. **Insurance Card**. Your original insurance card is needed

Questions/Concerns for Dr. Germano:

Hint: Writing down your questions will help you remembering what is important to you at the time of your visit.

Office Location:
Mount Sinai Medical Center, Faculty Practice Suites, 5 East 98th Street, 8th Floor, New York, NY 10029
Ph. 212-241-9638

Patient Name Date

Medical History Questionnaire

DOB Age Sex Approx. Weight

Hand Usage: Left Hand Right Hand Ambidextrous

HISTORY OF YOUR PRESENT ILLNESS:

Why are you here to see Dr. Germano?

When did symptoms begin?

Have the symptoms worsened since they first started?

Patient Name Date

CURRENT MEDICATIONS AND DOSAGES THAT YOU ARE TAKING:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Check if you are taking any of the following

Plavix	Advil	Aspirin	Chemotherapy
Blood Thinners	Levonox	Alleve	Baby Aspirin

Chemotherapy Name: Date of the last dose:

ALLERGIES

Food: Shellfish: Iodine:
Medication: Sulfa: Penicillin:
Other:

SOCIAL HISTORY

Primary Language? Born in the US?

Matrimony Status: Single Married Divorced/Widow

Do you live alone? If YES, who is your care provider?

Who do you live with?

Do you have a family? If NO what is your support system?

Your Occupation If Retired, when did you retire?

Do you drink alcohol? If YES how much per week?

Do you smoke cigarettes or cigars? If YES, how many packs per day?

Have you ever smoked? If YES, how much and for how long?

Have you traveled recently outside the USA? If YES, Where?

Do you or have you ever used Drugs? If YES, what type & how much?

Patient Name Date

PAST MEDICAL HISTORY

Any reasons why you may have been seen by other specialty doctors?

Admitted to the Hospital?

Evaluated in the Emergency room?

Do you have any of the following **MEDICAL CONDITIONS**? (Please check to the best of your ability)

Abnormal Heart Beat	Alcoholism	Anemia
Anxiety	Asthma	Bleeding Disorder
Bronchitis	Cirrhosis	Clogged Arteries
Congestive Heart Disease	Crohns disease	Depression
Diabetes	Diverticulitis	Flu
Gout	Heart Disease	Hepatitis
High blood pressure	High cholesterol	HIV or AIDS
Hyperthyroidism (High)	Hypothyroidism (Low)	Kidney Disease
Kidney Failure	Kidney Stones	Liver Disease
Lupus	Multiple Myeloma	Multiple Sclerosis
Neurological Disease	Osteoarthritis	Osteoporosis
Paget's Disease	Parathyroid Disease	Peripheral Vascular Disease
Pneumonia	Prostate Problems	Pseudogout
Psoriasis	Rheumatoid Arthritis	Sarcoidosis
Sexually Transmitted Diseases	Stroke or CVA	Thalassemia or Sickle Cell
Tuberculosis	Ulcerative Colitis	

Have you ever been on medication for Tuberculosis?

Please List Any Other Illnesses:

Patient Name Date

PAST SURGICAL HISTORY

Please list any surgical procedures that you have undergone along with the date or age that the procedure was performed:

Procedure Date or Age

Have you required general anesthesia?

Did you ever have a problem with general Anesthesia?

If yes, please describe:

Do you have a bleeding problem or bruise easily?

FAMILY HISTORY

Please tell us about your parents if they are still alive and their health issues:

Father Mother

If you have siblings indicate age and any health issues:

Brother Sister

Brother Sister

If you have children indicate age and health issues:

If your relatives have any other health issues describe below:

Has anyone in your family had a history of a Cancer, Sarcoma or Benign or Malignant Tumor?

If Yes, What type of cancer or tumor and what family members?

Patient Name Date

REVIEW OF SYSTEMS

Do you have any of the following signs or symptoms? (Please check to the best of your ability)

System	Sign/Symptom/Procedure	System	Sign/Symptom/Procedure
General	Change in energy level	**GI**	Black stools
	Fevers		Blood in stool
	Hair loss		Constipation
	Loss of appetite		Diarrhea
	Night sweats		Heart burn
	Swelling		Hernia
	Unable to sleep		Incontinence of stool
	Weight change		Incontinence of urine
HEENT	Blurred vision		Nausea
	Dentures		Reflux
	Difficulty swallowing		Swollen abdomen
	Double vision		Ulcer
	Hearing loss		Vomiting
	Neck pain		Yellow eyes
	Seasonal allergy		Yellow skin
	Sinus history	**Renal/GU**	Abnormal breast tissue
	Trigeminal nerve issues		Enlarged prostate
	Vision change		Frequent urination
Resp	Cough		Menopause
	Shortness of Breath		Prostatitis
	Shortness of Breath at Rest		Stress incontinence
	Shortness of Breath with Activity		Testicular pain
Cardiac	Atherosclerotic heart disease		Urgency
	Cardiac catheterization		Urine infections
	Carotid artery disease	**Endo**	Always thirsty
	Chest pain		Hot flashes
	Dizziness	**Hem/Onc**	Anemia
	High cholesterol		Difficulty healing
	Light headed with change in position		Easy bruising
	Medication for feet swelling		Fatigue
	Plaque in your vessels		Iron deficiency
Neuro/ Mus	Bone or joint pain		Need for oxygen
	Gait disturbance		Other Need for blood transfusion
	Muscle weakness	**Other**	
	Numbness		
	Restricted joint motion		
	Seizures		

Patient's Signature: