Weill Cornell Medicine
Sandra and Edward Meyer Cancer Center

NewYork-Presbyterian
Ronald P. Stanton Clinical Cancer Program

Christopher E. Barbieri, M.D., Ph.D.

Assistant Professor of Urology
Assistant Professor of Cell and Developmental Biology

Brady Urologic Health Center
525 East 68th Street, Starr 900
New York, NY 10065

Phone: 212-746-5562
Fax: 212-746-0975

NEW PATIENT HISTORY FORM

All information is confidential and will become part of your medical record.
PLEASE PRINT CLEARLY and do not leave any boxes empty, mark N/A for not applicable or none if appropriate.

PATIENT DEMOGRAPHICS			
Patient Name:			Date of Visit:
Date of Birth:	**Sex**: ❑F ❑M	**Social Security Number:**	**Email:**
Home Address:			**Home Phone:**
			Cell Phone:
Employer:			**Occupation:**

GENERAL INFORMATION		
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Domestic Partner		Spouse/Significant Other's name:
Ethnic group: ❑ Hispanic/Latino or Spanish Origin ❑ Not Hispanic/Latino or Spanish Origin ❑ Declined	**Race:** ❑ American Indian or Alaska nation ❑ Asian ❑ Black or African American	❑ Native Hawaiian/Other Pacific Islander ❑ White ❑ Declined ❑ Other combination

EMERGENCY CONTACT		
Name:	**Relationship:**	**Number:**

REFERRING PROVIDER	PRIMARY CARE PHYSICIAN
Name:	**Name:** ❑ Same
Specialty:	**Phone Number:**
Phone Number:	**Fax Number:**
Address:	**Address:**

PREFERRED PHARMACY	ALTERNATE PHARMACY
Name:	Name:
Phone Number:	Phone Number:

MEDICAL HISTORY

Please include all medical problems even if not relevant to this visit. If no medical problems, write none.

Medical Problems	Dates	Reasons

Hospitalizations/Surgeries	Dates	Reason

Medications/Supplements	Dosage/Frequency	Condition/Reason

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

FAMILY HISTORY

Mother	Father	Siblings	Children
❑ Alive ❑ Deceased ❑ Unkn	❑ Alive ❑ Deceased ❑ Unkn	❑ Alive ❑ Deceased ❑ Unkn	❑ Alive ❑ Deceased ❑ Unkn
❑ Heart Disease	❑ Heart Disease	❑ Heart Disease	❑ Heart Disease
❑ Diabetes	❑ Diabetes	❑ Diabetes	❑ Diabetes
❑ Cancer (Type:)	❑ Cancer (Type:)	❑ Cancer (Type:)	❑ Cancer (Type:)
❑ Other:	❑ Other:	❑ Other:	❑ Other:

SOCIAL HISTORY

Do you drink alcohol?	Do you smoke?	Do you use recreational drugs?
❑ Wine ❑ Beer ❑ Liquor ❑ I have _____ drink(s) per week ❑ I used to drink but quit in ____(year)	❑ 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? ❑ Yes ❑ No	**If yes, how often and what type?**

How did you hear about us?

❑ Physician ❑ Family/Friend ❑ Internet ❑ Health Plan ❑ Advertisement ❑ Referral Service ❑ International Office

REVIEW OF MEDICAL HISTORY

Please check the box if you are <u>currently</u> experiencing any of the following:

Constitutional
- ❑ Fever
- ❑ Chills
- ❑ Night sweats
- ❑ Weight loss/gain
- ❑ Sleep disturbance
- ❑ Fatigue
- ❑ Poor appetite

Eyes
- ❑ Rx glasses or lenses
- ❑ Blurry vision
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Retinal detachment
- ❑ Macular degeneration
- ❑ Blindness
- ❑ Redness
- ❑ Tearing
- ❑ Dryness
- ❑ Double Vision
- ❑ Discharge
- ❑ Pain

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

Respiratory
- ❑ Asthma
- ❑ Emphysema/COPD
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Aspiration
- ❑ Tracheotomy
- ❑ Tuberculosis
- ❑ Coughing blood
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Cough over 3 months

Nose
- ❑ Congestion
- ❑ Mucus
- ❑ Post nasal drip
- ❑ Sinus infection
- ❑ Sinus headaches
- ❑ Nose Bleeds

Allergy
- ❑ Sneezing
- ❑ Runny Nose
- ❑ Itchy ears, eyes, or nose
- ❑ Transplant
- ❑ Hives

Throat
- ❑ Voice problems
- ❑ Swallowing problems
- ❑ Throat Pain
- ❑ Phlegm
- ❑ Feeling of something stuck
- ❑ Tonsil infections/problems

Sleep
- ❑ Snoring
- ❑ Sleep Apnea
- ❑ CPAP/BiPAP/AutoPAP
- ❑ Insomnia
- ❑ Choking/Gasping
- ❑ Restless leg
- ❑ Daytime sleepiness

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

Gastrointestinal
- ❑ Diarrhea
- ❑ Constipation
- ❑ Blood in stool
- ❑ Vomiting/nausea
- ❑ Ascites
- ❑ Heartburn/acid reflux
- ❑ Abdominal pain
- ❑ Gallstones
- ❑ Pancreatitis
- ❑ Jaundice

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

Hematologic
- ❑ Bruise easily
- ❑ Anemia
- ❑ Leukemia/Lymphoma
- ❑ Blood clots
- ❑ Bleeding disorders
- ❑ History of radiation

Oral/Dental
- ❑ Dentures/implants
- ❑ Temporomandibular joint
- ❑ Teeth clenching/grinding
- ❑ Tongue problems
- ❑ Mouth lesions

Genitourinary
- ❑ Frequent urination
- ❑ Prostate problems
- ❑ Urine/bladder infections
- ❑ Yeast infections
- ❑ Incontinence
- ❑ Kidney problems/stones

Skin
- ❑ Skin cancer
  Type: _____
- ❑ Eczema
- ❑ Rash or skin sensitivity
- ❑ Abnormal skin moles
- ❑ History of skin disease
- ❑ Hair loss/growth
- ❑ Itching
- ❑ Keloid scars

Musculoskeletal
- ❑ Neck pain
- ❑ Arthritis
- ❑ Back pain/spinal issues
- ❑ Fractures
- ❑ Muscle pain
- ❑ Swelling
- ❑ Joint/bone pain

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

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Bi-polar
- ❑ Psychosis

Men's/Women's Health
- ❑ Sexual problems
- ❑ Genital lesions
- ❑ Abnormal discharge
- ❑ Cancer
  Type:_____

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):
Today's Date:	Signature: