Weill Cornell Medical College

**Parkinson’ Disease and Movement Disorder Institute**

- 428 East 72nd Street (Between 1st Avenue & York Avenue), Suite 400 (Ground Floor), NY, NY 10021
  Telephone: 212-746-2584   Fax: 646-962-0517

- 156 William Street, 11th Floor (Between Ann Street and Beekman Street), NY, NY 10038

**Instructions for your New Patient Visit:**

Appointment Date and Time: ____/____/____ at ____:____ AM / PM

**PLEASE REQUEST WEILL CORNELL CONNECT CODE AT VISIT**

Your Doctor:
- Claire Henchcliffe, MD, DPhil
- Alexander Shtilbans, MD, PhD
- Harini Sarva, MD
- Natalie Hellmers, MSN, RN, ACNP-BC

Approximate Visit Length: 60 minutes

- Attached Questionnaire
- Office notes and letter from your current Neurologist (If you have one.)

Please also bring to your appointment:
- Current Medication / Vitamin List (with strengths and dosages)
- Films/ CDS and Reports of relevant imaging (such as MRIs and CT Scans)
- Test Results (such as blood tests and EMG)
- Insurance Cards

★ **Cancellation Policy:** Our staff will call you in advance to confirm your scheduled appointment. If you are unavailable when we call, then we request that you call back as soon as possible to confirm. We reserve the right to cancel any appointments that have not been confirmed at least 2 business days in advance. We will also cancel if we have not received the attached questionnaire and letter from your primary care physician. These are mandatory for your visit. If advanced notification is not given regarding cancellations or changes to your appointment, you will be marked as a 'No Show'. If you accumulate 3 ‘No Shows’ within 1 year, the physician has the right to dismiss you from the practice. Last, we ask that you are prompt to your appointment. Should you arrive late, you may run the risk of forfeiting your appointment. Thank you for your cooperation. ★
Name: _____________________________________________________  Appointment Date: ____________________
Address: _____________________________________________________________________________________________
Date of Birth: __________________________
Age: ___________

Phone Numbers:
Home: (______) __________________________
Work / Daytime: (______) __________________________
Fax: (______) __________________________
Mobile Phone: (______) __________________________
Health Care Proxy: __________________________ Relationship: __________________________
Phone Number: (______) __________________________
E-mail Address: __________________________

Do you have an official copy of your Health Care Proxy Form? Yes / No

If yes, Please provide us with a copy
Phone number: (______) __________________________
Emergency Contact Person:
Name: __________________________ Relationship: __________________________
Phone Number: (______) __________________________

What is your preferred Pharmacy?
Name / Branch: __________________________
Address: __________________________
Phone Number: (______) __________________________

Who is your Primary Care Provider (Internist)?
Name: __________________________
Address: __________________________
Phone Number: (______) __________________________

Is this appointment a second consultation on a diagnosis?  Yes / No
Who referred you to our center?

Name: ____________________________________________ Specialty: ___________________________
Address: _______________________________________________________________________________________
Phone number: (______) __________________________
Fax number: (______) ___________________________
Would you like us to send our consultation note to this person? Yes / No

What is the major neurological problem that brings you to the office today? Please make sure to have provided also your medical records for today’s visit. ____________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Please circle any of the following that you have experienced as part of your illness:

- Slowness
- Changes with voice
- Clumsiness
- Difficulty walking
- Falling down
- Shoulder pain
- Memory Loss
- Weight Loss
- Depression
- Stiffness
- Other abnormal movements
- Changes in your handwriting
- Difficulty using your hands
- Balance Problems
- Poor posture/ hunching over
- Hallucinations
- Choking or Gagging
- Anxiety or panic attacks
- Acting out your dreams
- Tremor
Past Medical History
What medical problems do you have (or have you had in the past)? Please include hospitalizations.

_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________

List all surgeries or accidents that you have had, and the dates.

_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________

Smoking History:
Smoking Status circle one: Current, Never, Former
Quit date:
Types: Cigarettes, cigar, pipe
Packs per day
Years
Types: Snuff, Chew, smokeless tobacco
Quit Date: __________________________
Alcohol: Yes / No
Intake per week:
    ______ Wine
    ______ Beer
    ______ Liquor

Recreational drug usage? Y / N
If yes, which type: ___________________________________________________________

Occupation: ________________________________________________________________
Employer: __________________________
Marital Status: __________________________
Spouse name: __________________________
Number of children: ______
Years of education: ______
Family History:
Please fill in the table below for your parents
Name:
Mother:_________________________________________________________ Age:_____ Alive? Y / N
Father:_________________________________________________________ Age:_____ Alive? Y / N

Please list of any of your relatives have the following: (Father, mother, aunts, uncles, siblings, children, cousins, etc.)

Alzheimer’s

Anxiety

Ataxia

Attention Deficit Disorder

Bipolar

Dementia

Depression

Dystonia

Essential Tremor

Huntington’s Disease

Impulse Control Disorder

Movement Disorder

Parkinsonism

Parkinson’s Disease

Substance abuse disorder

Other neurological disorder

Caffeine: Y / N?
Do you use assistive devices? Y / N
Do you have a home health attendant? Y / N

Current height ______
Current weight ______
Allergies to medication or food? Please list reaction

________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

Are you allergic to contrast dye? Y / N

________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

Current Medications for Neurological conditions, Vitamins, and Supplements:
Please list the medication name, your dose, and when you take it.

________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

Any medications you may have taken for your neurological condition in the past that did not work:

________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

Any other medications or supplements that you currently take:

________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
In the past week, which symptoms have you experienced?

Please circle all that apply.

**Whole body symptoms**
- Weight loss or gain
- Fever
- Chills
- Night Sweats
- Poor Appetite
- Fatigue
- Insomnia
- Excessive daytime sleepiness

**Eye Problems**
- Vision Changes
- Double vision
- Eye pain or discharge
- Dry eyes

**Ear, nose, throat, or mouth problems**
- Hearing loss
- Ringing in the ears
- Ear pain
- Ear discharge
- Stuffy nose
- Runny nose
- Postnasal drip
- Nosebleeds
- Mouth Sores/Lesions
- Sore throat
- Swallowing problems

**Heart or blood vessel problems**
- Chest pain
- Palpitations
- Swelling
- Leg pain with walking
- Lightheadedness/near fainting
- Fainting
- Poor exercise tolerance

**Lung or breathing problems**
- Shortness of breath
- Coughing

**Gastrointestinal problems**
- Coughing up blood
- Wheezing
- Excessive phlegm
- Upset stomach or reflux
- Nausea
- Vomiting
- Abdominal pain
- Diarrhea
- Constipation
- Bloody or black stool
- Yellowing of the skin

**Musculoskeletal problems**
- Bone pain
- Muscle pains
- Joint pains
- Fractures

**Genital or urinary problems**
- Frequent urination
- Urgency to urinate
- Waking at night to urinate
- Painful or bloody urination
- Urinary incontinence
- Penile / vaginal discharge
- Genital lesions
- Erectile dysfunction
- Abnormal vaginal bleeding
- Abnormal menses

**Skin problems**
- Rashes
- Ulcers
- Abnormal hair loss
- Skin changes

**Endocrine problems**
- Heat intolerance
- Cold intolerance
- Urinating too often
- Abnormally thirsty
Other neurological symptoms
Weakness
Headache
Convulsions or Seizures
Vertigo
Tingling

Psychiatric Symptoms
Anxiety
Panic attacks
Depression
Hallucinations / illusions

Blood / lymphatic problems
Easy bleeding
Easy bruising
Swollen glands

Allergic / Immunology problems
Hives
Anaphylaxis
Skin tightness
Morning stiffness
Fingers changing color in the cold