

Joan and Sanford I. Weill  
Medical College

Department of Neurological Surgery  
525 East 68th Street, Box 99  
New York, NY 10021

Telephone: 212 746-4684  
Fax: 212 746-8190

---

Dear \_\_\_\_\_,

We are pleased to welcome you to the Department of Neurological Surgery at Weill Medical College. In the pages that follow you will find information pertinent to your upcoming visit. These items include:

- Department of Neurological Surgery Profile
- Information & Reminder Sheet
- Patient registration forms
- Directions to our facility

You may print these forms and mail them back to your scheduled physician's office or fax them to the number listed below. In order for us to prepare for your visit, we ask that you return these forms as quickly as possible to your physician's office. We hope that you find this information helpful in preparation for your appointment. If we can assist you further please do not hesitate to contact us at: 212-746-4684.

Sincerely,

The Department of Neurological Surgery  
Weill Medical College

**FAX #:** \_\_\_\_\_

WEILL MEDICAL COLLEGE OF  
CORNELL UNIVERSITY  
DEPARTMENT OF NEUROLOGICAL SURGERY

The Department of Neurological Surgery of The Weill Medical College of Cornell University and the New York Presbyterian Hospital provides state-of-the-art care to patients with neurological diseases and disorders requiring surgical intervention and specialty medical management. Our collection of world-class faculty focuses attention on patient care, teaching and research. Each faculty member provides responsive and compassionate care utilizing cutting-edge technology (i.e., intra-operative MRI, brain mapping, gene therapy, Gamma Knife and Linac radiosurgery, minimally invasive aneurysm therapy, frameless stereotaxy, and angiography) to provide patients with their best chance for recovery. Additionally, the medical staff plays an important role in teaching medical students, residents and fellows and providing continuing medical education to neurosurgeons around the world. Clinical trials and laboratory efforts focusing on brain protection and nerve cell regeneration are performed in close conjunction with our neurology colleagues.

The department focuses its surgical efforts towards specific neurologic diseases such as: aneurysm, AVM and stroke; brain tumors; cerebrovascular disorders; endovascular techniques; epilepsy; movement disorders; pain; pediatric neurosurgery; radiosurgery; skull-base surgery; and spinal disorders. Individual members of the department work as part of a multidisciplinary team creating specialty centers in each of these disease categories. It is our strong belief that it takes the combined skills of neurosurgeons, endovascular surgeons, neurologists, neuroradiologists, and anesthesiologists to diagnose and manage this comprehensive range of neurologic diseases. Neurosurgeons have long focused on minimally invasive techniques such as microsurgery. More recently, endovascular techniques as well as stereotactic radiosurgery, frameless stereotaxy and endoscopic surgery have all played a role in our ability to minimize surgical exposure and improve outcomes. Most recently, we have developed the technology for operating within an MRI scanner to confirm our surgical goals on a real-time basis.

The department works closely with care coordinators, nursing staff and social work to provide compassionate and thorough patient care. The needs of each patient are unique and the department is committed to providing an individualized plan of treatment and support for each patient and their family.

Finally, the department interacts closely with fellow neuroscientists in performing translational research in an effort to move treatment from the laboratory into the clinical setting. Infusion of drugs and growth factors may prove to be of benefit in neurologic diseases. In addition, new technology using stem cell biology for the treatment of many neurologic disorders such as stroke and brain tumors may provide new therapeutic options for our patient population. Great new vistas exist for the treatment of neurologic disease and the department will play a leading role in the implementation of these new treatment paradigms.

The Department of Neurological Surgery stands ready to deliver outstanding care with compassion and concern for each patient.

## What to Bring to Your Appointment

**In order to enable your physician to properly evaluate your condition please bring the following items to your appointment:**

- All radiological studies (CT, MRI, X-ray) pertaining to your current medical problem. Medical reports of these studies are not sufficient; you must bring the actual radiological films with you to be reviewed. Please do not send films prior to your appointment unless you are asked to do so.
- Prior medical records and consultations from other physicians who have evaluated your medical problem should also be hand carried to your appointment unless prior arrangements have been made with your physician.
- A complete list of the names and dosage of all the medications that you are taking.
- If you have heart disease or have been hospitalized with a heart problem, it is necessary to bring a recent summary from your cardiologist or primary care physician.
- Your insurance card if applicable.

### **A checklist for your visit:**

The following list will help you remember items and information to bring with you to your appointment.

- Completed patient questionnaires
- Medical records (consultation, operative, radiology reports)
- Radiological films (CT, MRI, X-ray)

If applicable, please bring the following:

- Letter of authorization from your insurance carrier
- Insurance card
- Other \_\_\_\_\_

## Your appointment

### **Length of Your Visit**

Please allow 1-2 hours for your appointment. Your physician will spend as much time needed to ensure appropriate assessment and understanding of your care. Please prepare for possible delays with the assurance that you too will have the time you need with your doctor.

### **Medical Care**

As our patient, you will receive the finest in consultation assistance and surgery by our neurosurgeons. Nurses, technicians, and trainees may assist your doctor during your visit. These individuals have special training and skills that make them an important part of our patient care team.

### **Food & Beverage**

There is *no* food or drink allowed in our Neurological Surgery Suite. However, you may visit The Patio Café located on the first floor of the Hospital Lobby, (across from the information desk) for a snack or a meal.

### **Overnight Accommodations**

The following are a list of hotels and contact numbers which are located near our facility.

Helmsley	1320 York Avenue New York, New York	212-472-8400
Belair	525 East 71 <sup>st</sup> Street New York, New York	212-606-1989
Bentley	500 East 62 <sup>nd</sup> Street New York, New York	212-644-6000
Pickwick	230 East 51 <sup>st</sup> Street New York, New York	212-355-0300
Regency	540 Park Avenue New York, New York	212-759-4100

Joan and Sanford I. Weill  
Medical College

Department of Neurological Surgery  
525 East 68th Street, Box 99  
New York, NY 10021

Telephone: 212 746-4684  
Fax: 212 746-8190

**PATIENT MEDICAL HISTORY**

Today's Date: \_\_\_\_\_

*Physician Name: Please circle the name of the physician with whom you have an appointment.*

- DR. J. BOOCKVAR    DR. A. COHEN    DR. P. GOBIN    DR. R. HARTL    DR. M. KAPLITT    DR. H. RIINA  
DR. SCHWARTZ    DR. M. SOUWEIDANE    DR. P. STIEG    DR. M. ZONENSHAYN    DR. S. PANNULLO

*Patient Information*

Patient Name: \_\_\_\_\_  
(First) (Middle) (Last)  
Home Address: \_\_\_\_\_  
(Street Name and #) (City, State) (Zip Code)  
Phone: \_\_\_\_\_  
(Home) (Business)

*Demographic Information*

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Occupation: \_\_\_\_\_

*Referral Information*

How were you referred to us? WEBSITE    INSURANCE    FAMILY/FRIEND    EMERGENCY ROOM  
OTHER \_\_\_\_\_ BRAIN/SPINE ORGANIZATION: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_

*Health Information*

Reason for today's visit: \_\_\_\_\_  
Other diseases and/or problems:  
(1) \_\_\_\_\_  
(2) \_\_\_\_\_

*Lifestyle Information*

Do you smoke? \_\_\_\_ How many packs a day? \_\_\_\_ How many years? \_\_\_\_ Quit? When \_\_\_\_  
Do you drink alcohol? \_\_\_\_ How often? \_\_\_\_\_ How much? \_\_\_\_\_  
Do you use recreational drugs? \_\_\_\_ Which Drugs? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you exercise regularly? \_\_\_\_ How often? \_\_\_\_\_ What type of exercise? \_\_\_\_\_

Patient Name : \_\_\_\_\_

**Please indicate if you have any of the following:**

- |                            |  |                              |  |
|----------------------------|--|------------------------------|--|
| Anemia                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV disease                  | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Arthritis                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney/urinary problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Asthma                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Memory loss                  | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Bleeding/clotting disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Numbness or pain in fingers  | <input type="checkbox"/> in toes <input type="checkbox"/> arms <input type="checkbox"/> legs |
| Cancer (Type)              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neuromuscular diseases       | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Chest Pain                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rashes                       | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Depression                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ringing in ears              | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Diabetes                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Difficulty speaking        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/intestinal problem   | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Difficulty swallowing      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke/CVA                   | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Dizziness/fainting         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling arms/legs           | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Emphysema                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thrombophlebitis             | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Fevers                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid/Parathyroid Disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Glaucoma/cataracts         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Transplant (donor/recipient) | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Gout                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                 | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Headaches                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers (GI/Duodenal)         | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Hearing loss               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Unplanned weight loss        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Heart Disease              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weakness in arms/legs        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| High Cholesterol           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
| High Blood Pressure        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |

**Please list any medications you are currently taking:**

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

**Are you presently taking aspirin or have you taken aspirin in the past 7 days?**  Yes  No

**Please list any herbal or over-the counter preparations you are currently taking:**

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

Patient name: \_\_\_\_\_

**FAMILY HISTORY:**

Has anyone in your family had the following?: ( Y / N )

___ Clotting/bleeding problems	___ Diabetes	___ Heart Disease
___ High blood pressure	___ High cholesterol	___ Stroke/ CVA

MOTHER:	___ Alive	___ Deceased	age at death _____	Cause _____
FATHER:	___ Alive	___ Deceased	age at death _____	Cause _____
SIBLINGS:	___ How many?	___ Alive		
		___ Deceased	age at death _____	Cause _____

**Have you ever been hospitalized for a reason other than surgery?**

Reason: _____	When: _____
Reason: _____	When: _____
Reason: _____	When: _____

**Have you ever had surgery?**

Reason: _____	When: _____
Reason: _____	When: _____
Reason: _____	When: _____

**Are you allergic to any medications?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**I believe the above information is complete to the best of my knowledge.**

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

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:


\_\_\_\_\_  
\_\_\_\_\_

Reviewed and discussed with patient: \_\_\_\_\_ Date: \_\_\_\_\_

# CORNELL PHYSICIANS

at the  
NEW YORK WEILL CORNELL MEDICAL CENTER

E 72nd Street  
Medical Offices  
428




E 71st Street  
Stich  
Medical  
Offices  
1319

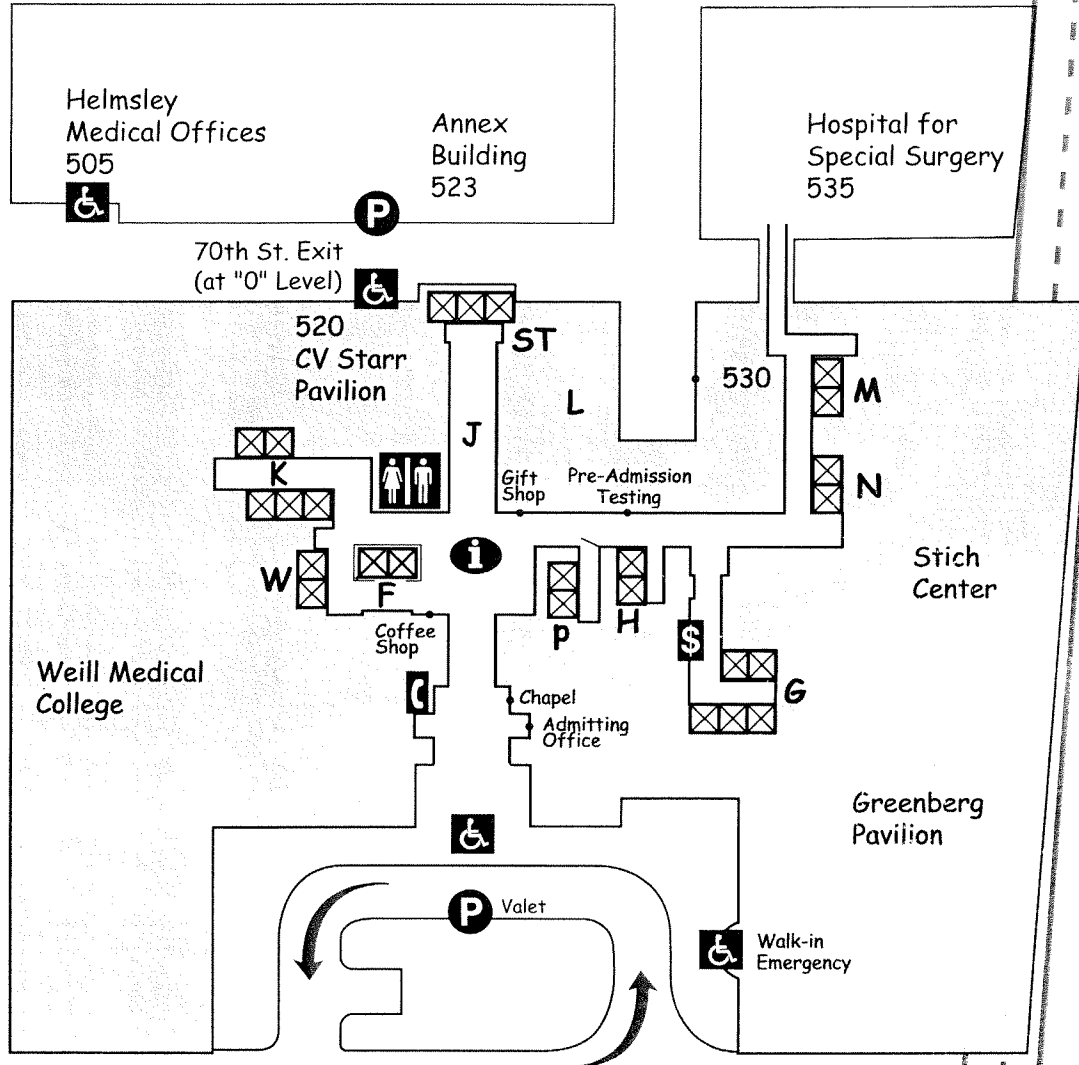


E 70th Street  
York Avenue

E 69th Street  
International  
Health  
Services  
440



E 68th Street



Main Entrance 525 East 68th Street

-  INFORMATION DESK
-  RESTROOMS
-  ELEVATORS
-  TELEPHONES
-  WHEEL CHAIR ACCESSIBLE
-  PARKING
-  AUTOMATIC TELLER MACHINE

TO GET TO:	TAKE:
BAKER PAVILION, F 9-24 FL.	F ELEVATORS
F 2-8 FL.	K ELEVATORS
21st FL. DENTAL OFFICES	H ELEVATORS
GREENBERG PAVILION	G ELEVATORS
K BUILDING	K ELEVATORS
L100	HALLWAY TO THE RIGHT OF INFORMATION DESK
M BUILDING	M ELEVATORS
N BUILDING	N ELEVATORS
PAYSON PAVILION	P ELEVATORS THROUGH GLASS DOOR
STARR PAVILION, J WING, L BLDG.	ST ELEVATORS
STICH CENTER	N ELEVATORS TO BASEMENT LEVEL
WHITNEY PAVILION	W ELEVATORS