NYU Langone Health

Dear Patient,

In accordance with HIPPA regulations, we take your privacy very seriously. To help us better protect your confidential information, please complete the form below.

Patient Name	
Date of Birth:	

I authorize the person(s) listed below to communicate with the Fresco Institute physicians and staff regarding the following information pertaining to my medical care:

Initial all that apply:

	Schedule, confirm, cancel my appointment
	Request medication refills
	Discussing any or all of my medical care including evaluations, treatment, diagnosis even if related to psychiatric or psychosocial impairments, pregnancy, substance abuse, acquired immunodeficiency virus (AIDS) or HIV-related opportunistic infection.

Name of the person that you would allow us to release medical information to	**Relationship**	**Telephone No.**

_____ _____

Patient signature Date

Marlene and Paolo Fresco Institute for Parkinson's and Movement Disorders

New Patient Intake Questionnaire

Name: _____ **Appointment Date:** _____

Date of birth: _____ **Handedness:** Right Left Ambidextrous

Who referred you to our center?

Name: _____ Address: _____

Phone number: ( ) _____ Fax number: ( ) _____

Type of Doctor (if relevant): _____

Who is your internist, general doctor, or primary care provider?

Name: _____ Address: _____

Phone number: ( ) _____ Fax number: ( ) _____

Type of Doctor (if relevant): _____

Demographics:

Occupation: _____ Name of employer: _____

Employment status (circle one): Working full time Working part-time Student
Short-term disability Long-term disability Retired

Highest grade level or degree(s): _____

Marital status (circle one): Single Married Separated
Divorced Widowed Domestic Partner

Spouse's/Domestic partner's name (if any): _____

How many children do you have? _____ Who lives at home with you? _____

In which country were you born? _____

Countries of your ancestors? _____

NYU Langone
MEDICAL CENTER

Pharmacy Information

With the installation of Epic, the new electronic medical record system, at this practice, your doctor is now able to e- prescribe. This means that any prescriptions the doctor may give you today will be automatically routed to the pharmacy of your choice and we will no longer have to provide you with handwritten prescriptions. In addition, when you run out of refills on your medication, the pharmacist can now electronically send renewal requests to this office for approval.
**Note: Controlled medications are not eligible for e-prescribing.

Please complete the information below if you are interested in e-prescribing.

Patient Name: _____

Preferred Pharmacy		Alternate Pharmacy	
Name of Pharmacy:		Name of Pharmacy:	
Address:		Address:	
City:		City:	
State:		State:	
Zip Code:		Zip Code:	
Phone Number:		Phone Number:	
Fax Number:		Fax Number:	

Laboratory Information

Please indicate by placing a checkmark next to one of the options below to identify your preferred laboratory. Some insurance plans require that covered patients utilize specific laboratories; failure to follow their guidelines can lead to bills that become the patient's responsibility. If you do not know which laboratory to select, please contact your insurance carrier. **If you do not select a laboratory, the practice will default any lab tests to NYU laboratory.**

LabCorp	
Quest Labs	
NYU Lab	
Sunrise Laboratory	
Other External Location	

Please provide name of external location: _____

What is the **major neurological problem** that brings you to the office today?

_____

_____

_____

Current Medications, Vitamins, and Supplements:

Please list the medication **name**, **dose,** and **timing**.

Examples: Carbidopa-Levodopa 25/100 mg, 2 tablets 5 times daily at 8-12-2-4-8
Melatonin 3 mg tablets, 1 tablet every evening

Medication:	Supplements:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies:

Are you allergic to any medications, foods, or contrast dye? Yes No

What are you allergic to? What is your reaction? _____

Personal and Social History:

Do you smoke? Yes No When did you start? _____How many packs/day?_

Are you a prior smoker? Yes No When did you quit? _____

How much alcohol do you drink?
Glasses wine/week_____
Number of beers/week_____
Ounces liquor/week_____

How many cups per **week** of caffeinated drinks (i.e. coffee, tea, soda) do you **currently** use:_____

Do you **currently** use recreational drugs? Yes No Which one(s)? _____

Have you **ever** used recreational drugs? Yes No Which one(s)? _____

Are you sexually active? Yes No

For women only:
Are you currently use (circle): Birth Control Pills IUD

Are you planning to become pregnant in the next year? Yes No

Age of Menopause: _____or N/A

Please circle any tasks that you are having difficulty with and/or need help with:

Basic:

Bathing	Toileting	Eating
Dressing	Transferring	Drinking
Personal hygiene	Walking	Other: _

Instrumental:

Cleaning	Managing finances	Getting to and from appointments
Cooking	Taking medications	Other: _____
Shopping	Using the telephone or computer	

Past Medical and Surgical History:
(If you provided this information online, please skip)

What medical problems do you have (or have you had in the past)?
Please include hospitalizations.

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

Family History (including parents, siblings, children):
(If you provided this information online, please skip)

Name	Relationship	Current Age (or age at death)	Medical problems (and/or cause of death)	Alive (Y/N)?