University of Rochester Neurosurgery Group

New Patient Information Sheet

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Multidisciplinary Neuro-Endocrine Clinic

Patient Name:

Date of Birth:

Primary care Physician:

Referring Physician:

Address:

Phone:

Please describe the reason of your visit:

Symptoms:

When did symptoms begin?

When does the pain/problem occur (i.e.: morning/night):

What aggravates the symptoms:

What reduces the symptoms:

Place check if you have other symptoms:

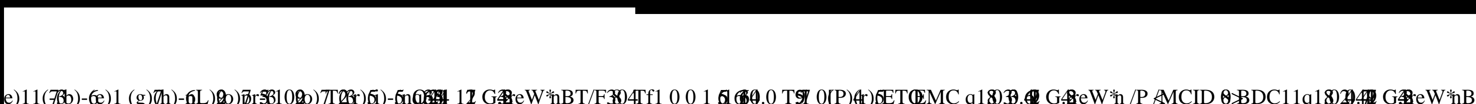
Shade the areas you have pain:

Symptom	Occurrence	Location
☐ Numbness	☐ Constant	

ALLERGIES: ☐ **NONE**

List all known allergies to **medication, food, or latex**

NAME OF MEDICATION/FOOD/LATEX	TYPE OF REACTION



ENDOCRINE REVIEW

Please complete to the best of your ability:

CONSTITUTIONAL:

Good appetite?	☐ Yes	☐ No
Fever/Chills?	☐ Yes	☐ No
Night sweats?	☐ Yes	☐ No
Unintentional weight loss?	☐ Yes	☐ No
Unintentional weight gain?	☐ Yes	☐ No
Excessive fatigue?	☐ Yes	☐ No

Comments:

EYES:

Dryness?	☐ Yes	☐ No
Persistent redness?	☐ Yes	☐ No
Loss of vision?	☐ Yes	☐ No
Visual disturbances?	☐ Yes	☐ No
Irritation?	☐ Yes	☐ No

Comments:

EARS/NOSE/THROAT:

Hearing loss?	☐ Yes	☐ No
Ringing in ears?	☐ Yes	☐ No
Nosebleeds?	☐ Yes	☐ No
Chronic sinus congestion?	☐ Yes	☐ No
Heavy snoring?	☐ Yes	☐ No
Change in voice?	☐ Yes	☐ No

Comments: