DENT
NEUROLOGIC INSTITUTE

716.250.2000 | dentinstitute.com

NYC | 2689 Broadway, New York, NY 10025

Dear Patient:

Thank you for choosing the Dent Neurologic Institute, New York's premier Neurologic and Diagnostic Center.

Patients are required to arrive 30 minutes prior to their appointment time for the initial consultation. This time will be used to complete the registration process. Thank you for your understanding!

In order to ensure a positive experience, please be prepared with the following items on the day of your visit. Failure to comply may result in our need to reschedule your visit.

Documents: You must complete all the enclosed documents prior to your appointment time. COMPLETION OF YOUR MEDICAL INTAKE FORMS IS CRITIAL IN ORDER FOR OUR PHYSICIANS TO APPROPRIATELY TREAT AND DIAGNOSE. You must complete the application forms in their entirety.

Patient Portal: Dent requires that you sign up to become web enabled. This will allow you to process and submit forms/questionnaires, communicate with your Dent Provider, request medication refills, and access applicable test results ordered by your Dent Provider.

Payment: This office is self-pay only. We do not accept insurance at this location. Full payment is required at the time of service.

Identification: You must provide us with photo ID or two other forms of identification.

Diagnostic Results: Test results, diagnostic reports, films and CDs from all physicians treating you are REQUIRED at visit.

Be sure to visit our website at www.dentinstitute.com for information about Dent and access to your on-line secured medical record.

Once again, thank you for choosing the Dent Neurologic Institute. If you have any questions, please feel free to call us at 716-250-2000.

Advance Notice is Required for all Cancellations

If you fail to cancel an appointment at least one business day prior; or you do not show for your scheduled appointment, you will be assessed a non-timely cancellation fee.

DENT
NEUROLOGIC INSTITUTE

Dent Neurologic Institute

Manhattan Location

2689 Broadway

New York, NY 10025

DENT NEUROLOGIC INSTITUTE

REGISTRATION FORM

Today's Date:			
PATIENT INFORMATION			
Last Name:	**Middle:**	**First:**	
❑ **Mr.** / ❑ **Mrs.** / ❑ **Miss** / ❑ **Ms.**	**Marital Status (Check one):**	❑ **Single** / ❑ **Married** / ❑ **Divorced** ❑ **Separated** / ❑ **Widowed**	
Former Name:	**Preferred Name:**		
Birth Date:	**Sex:** ❑ **M** ❑ **F**	**E-mail Address:**	
Home Phone: ( )	**Cell Phone:** ( )		
Street Address or P.O. Box:			
City:	**State:**	**Zip Code:**	**Social Security Number:**
Primary Physician:	**Referring Physician:**		
Race:	**Ethnicity:**	**Language:**	
Pharmacy Name:	**Pharmacy Address:**	**Pharmacy Phone:**	
CONTACT PERSON IN CASE OF EMERGENCY			
Name:	**Relationship:**		
Home Phone: ( )	**Cell Phone:** ( )		
SEXUAL ORIENTATION / GENDER IDENTITY			
Sexual Orientation (Check one):	❑ **Lesbian, gay or homosexual** / ❑ **Straight or heterosexual** ❑ **Bisexual** / ❑ **Do not know** / ❑ **Choose not to disclose**		
	Something else, please describe:		
Gender Identity (Check one):	❑ **Male** / ❑ **Female** / ❑ **Female-to-Male (FTM), Transgender Male, Trans Man** ❑ **Male-to Female (MTF), Transgender Female, Trans Woman** ❑ **Genderqueer, neither exclusively male nor female** ❑ **Choose not to disclose**		
	Additional gender category or other, please specify:		

DENT NEUROLOGIC
NEW PATIENT HISTORY FORM

Today's Date _______________

Name: ________________________ DOB: _________ Age: __________

1. Please describe the problem that you would like addressed, e.g., what it consists of, how and when it started, what worsens and relieves it.

____

____

____

____

____

2a. Who is your **primary physician with address** (if known)?

____

____

2b. What physicians have you seen for this problem?

____

____

3. List all illnesses and/or hospitalizations/surgeries you have had during your life:

____________________________ ____________________________________

____________________________ ____________________________________

____________________________ ____________________________________

____________________________ ____________________________________

4. List any pain management procedures / injections like facet blocks, nerve blocks, or Botox therapy:

Procedure / Injection	Helpful?	Any Adverse Reactions?
________________________	❑ **Yes** ❑ **No**	______________________________
________________________	❑ **Yes** ❑ **No**	______________________________
________________________	❑ **Yes** ❑ **No**	______________________________
________________________	❑ **Yes** ❑ **No**	______________________________

Print Name: ____________________________

5. List the name and dose for each prescription and over-the-counter medication you are currently taking:

Drug:_______________________________ **Dose:**_______________________________

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

6. Any drug allergy?

Drug	Reaction
________________	________________
________________	________________
________________	________________

7. What has been done for your problem? Medications? Physical therapy? Surgery? Other?

Treatment	Date	Results
____________	________	________________
____________	________	________________
____________	________	________________
____________	________	________________

8. Other problems? Please **circle** the ones that apply to you:

Neurologic
Headache, change in taste, smell or hearing, slurred speech, difficulty swallowing, dizziness, weakness, numbness, loss of consciousness, fainting, seizure, unsteadiness, falls, tremor, confusion, memory loss, head trauma, sleep problem, stroke/TIA (mini-stroke)

Constitutional
Fever, chills, fatigue, weight gain or loss, HIV/AIDS

Eyes
Blurry vision, double vision, decreased vision, cataract, glaucoma

Ears, Nose, Mouth, Throat
Hearing loss, ringing in the ears, earache, hoarseness, vertigo (spinning)

Cardiovascular
Chest pain, palpitations, leg edema, high blood pressure, heart attack, coronary artery disease/surgery, shortness of breath when lying down or exertion, heart failure

Print Name: ______________________________

Continued from # 8

Respiratory
Cough, emphysema, asthma

Gastro-Intestinal
Nausea, vomiting, heartburn, ulcers, abdominal pain, diarrhea, constipation, hepatitis

Genito-Urinary
Urinary incontinence/frequency/urge, sexual dysfunction, kidney problems

Skin
Rash or other skin abnormality

Musculoskeletal
Joint pain/swelling/stiffness, neck/lower back pain, muscle aches

Psychiatric
Depression, anxiety, other psychiatric problems

Endocrine
Diabetes, thyroid problems, hormonal problems

Hematologic
Anemia, easily bruises, bleeding disorder

Allergy
Itching, rash, swollen lips/tongue

Have you ever had cancer ____ No ____ Yes, describe ___________________________________

9. Have you had any of the following tests?

Test	Date	Where
MRI	_______________	___________________________________
CT	_______________	___________________________________
Carotid Doppler	_______________	___________________________________
EMG	_______________	___________________________________
EEG	_______________	___________________________________
SPECT/PET	_______________	___________________________________

Other (myelogram, angiogram, biopsy, spinal tap):

_______________________	_______________	___________________________________
_______________________	_______________	___________________________________
_______________________	_______________	___________________________________
_______________________	_______________	___________________________________

Print Name: ____________________________

10. Do you use tobacco? ___ No ___Yes, pack per day ___, # of years____ Quit date ______

Do you use alcohol? ___ No ___ Yes, amount ______________________________

Who lives with you at home? ____

Describe your work: ____

____

Disability? _______ No ________ Yes, since _____________________________

11. Have you fallen in the past 12 months? ___ No ___Yes

Do you feel unsteady when standing or walking? ___ No ___ Yes

12. Tell us about your family's health:

Mother: ____

Father: ____

Brother #1: ___________________________ Sister #1: ________________________

Brother #2: ___________________________ Sister #2: ________________________

Brother #3: ___________________________ Sister #3: ________________________

Brother #4: ___________________________ Sister #4: ________________________

13. What do you hope to achieve with your doctor?

____

____

____

____

____

Print Name

____ ________________________

Signature Date

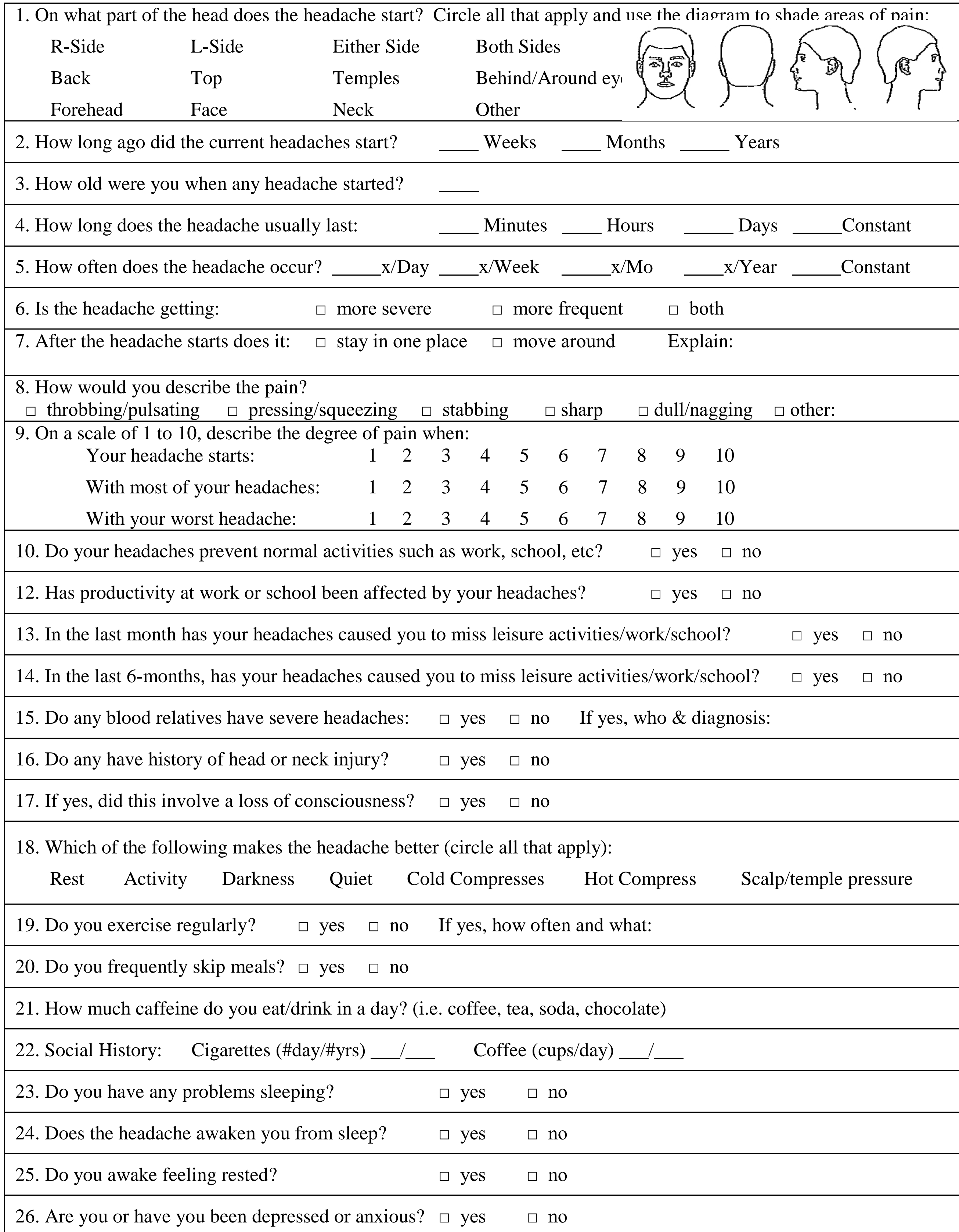
Tell Us How We're Doing!
Visit Our Website at www.dentinstitute.com and take our online survey

For office use only:

BP ____________________ Pulse _________ Resp. ________ Wt. _______ Ht. _______

Headache History & Profile Questionnaire

Name: ____________________ DOB: ________________ Date: ___________________



1. On what part of the head does the headache start? Circle all that apply and use the diagram to shade areas of pain:

R-Side	L-Side	Either Side	Both Sides
Back	Top	Temples	Behind/Around ey
Forehead	Face	Neck	Other

2. How long ago did the current headaches start? ____ Weeks ____ Months _____ Years

3. How old were you when any headache started? ____

4. How long does the headache usually last: ____ Minutes ____ Hours _____ Days _____Constant

5. How often does the headache occur? _____x/Day ____x/Week _____x/Mo ____x/Year _____Constant

6. Is the headache getting: □ more severe □ more frequent □ both

7. After the headache starts does it: □ stay in one place □ move around Explain:

8. How would you describe the pain?
□ throbbing/pulsating □ pressing/squeezing □ stabbing □ sharp □ dull/nagging □ other:

9. On a scale of 1 to 10, describe the degree of pain when:

Your headache starts:	1	2	3	4	5	6	7	8	9	10
With most of your headaches:	1	2	3	4	5	6	7	8	9	10
With your worst headache:	1	2	3	4	5	6	7	8	9	10

10. Do your headaches prevent normal activities such as work, school, etc? □ yes □ no

12. Has productivity at work or school been affected by your headaches? □ yes □ no

13. In the last month has your headaches caused you to miss leisure activities/work/school? □ yes □ no

14. In the last 6-months, has your headaches caused you to miss leisure activities/work/school? □ yes □ no

15. Do any blood relatives have severe headaches: □ yes □ no If yes, who & diagnosis:

16. Do any have history of head or neck injury? □ yes □ no

17. If yes, did this involve a loss of consciousness? □ yes □ no

18. Which of the following makes the headache better (circle all that apply):
Rest Activity Darkness Quiet Cold Compresses Hot Compress Scalp/temple pressure

19. Do you exercise regularly? □ yes □ no If yes, how often and what:

20. Do you frequently skip meals? □ yes □ no

21. How much caffeine do you eat/drink in a day? (i.e. coffee, tea, soda, chocolate)

22. Social History: Cigarettes (#day/#yrs) ___/___ Coffee (cups/day) ___/___

23. Do you have any problems sleeping? □ yes □ no

24. Does the headache awaken you from sleep? □ yes □ no

25. Do you awake feeling rested? □ yes □ no

26. Are you or have you been depressed or anxious? □ yes □ no

Associated Headache Symptoms:

Are any of the following symptoms associated with the headache? Please mark: **(B) Before (X) During (A) After**	
FACE AND SCALP:	**GENERAL:**
____ Spots before eyes R/L	____ Nausea
____ Blindness R/L	____ Vomiting
____ Blurring R/L	____ Stomach Cramps
____ Eyelid Droop R/L	____ Hunger
____ Tearing R/L	____ Loss of Appetite
____ Double Vision R/L	____ Diarrhea
____ Eye Redness R/L	____ Depression
____ Eyes Puffy R/L	____ Fatigue
____ See only half objects R/L	____ Anxiety
____ Noise Sensitivity	____ Irritability
____ Odor Sensitivity	____ Difficulty concentrating
____ Light Sensitivity	____ Difficulty talking or finding words
____ Nose Discharge R/L	____ Difficulty understanding
____ Nose Blocked R/L	____ Fainting or feel like fainting
____ Paleness	____ Slurred speech
____ Redness	____ Dizziness
____ Sweating	**NECK:**
____ Tenderness	____ Stiffness
____ Pain on chewing	____ Tenderness
____ Puffiness	**HANDS AND/OR FEET:**
____ Decreased jaw opening	____ Cold
PLEASE MARK IF YOU EXPERIENCE:	____ Pale
(W) Weakness (N) Numbness (B) Both	____ Sweaty
____ Face R/L	____ Mottled
____ Arms R/L	
____ Legs R/L	
____ Arm and Leg R/L	
____ Numbness around Lips	

Indicate if any of the following factors have (+) **Brought on** (trigger) or (++) **Worsened** your headache:			
____ Sleep too much or little	____ Missed Meal	____ Cheese	____ Medications (list)
____ Emotional stress	____ Change in Weather	____ MSG	____ Menstrual Periods
____ Depression - anxiety	____ Seasons	____ Other foods (list)	____ Pregnancy
____ Physical Activity	____ Processed Meats	____ Straining/Coughing	____ Menopause
____ Erect Position	____ Chocolate	____ Menstrual Periods	____ Oral Contraceptives
____ Bending Over	____ Citrus Fruits	____ Oral Contraceptives	

Patient Name: ___________________________

Chronic Migraine Screener

What is Chronic Migraine?
Chronic Migraine is a condition defined as 15 or more headache days a month with each headache lasting 4 hours or more per day. At least of half of the headaches should be migraine.
How to use this screener:
The following questions can help you and your physician understand your condition and help determine if you have Chronic Migraine. Being thorough about your headaches/migraines will help your physician determine how much of your headaches affect your daily life and help get you to a more accurate diagnosis and find treatment options that are right for you.

Personal Information

Name: ________________

Date of Birth: ________________

Important information before you get started

What are headache days?
It is important to understand the number of days you had *headaches* (including migraines) rather than the number of *attacks.*

- For example, you have a headache that starts on Monday and does not go away until Wednesday; it may be one attack, but that is considered 3 *headache days*

Remember to provide your doctor with an accurate number of **ALL of the days you experience pain of any kind.**

Are migraine days the same as headache days?
Some of your headaches may be a type of headache known as *migraine*. If you experience any combination of the following symptoms, your headache may be a migraine:

- Constant, throbbing pain felt on one side of the head (but can be on both sides)
- Sensitivity to light and sound
- Nausea and/or vomiting
- Headaches that get worse with movement (you may want to lay down)

Whether your headache is a migraine or not, it still counts as a *headache day.*

What if the headache gets better or goes away after I take medication?
You should also count days that you treated/resolved your headache/migraine with either an over-the-counter medication like ibuprofen or prescription medication like sumatriptan. These days are still considered as days *with* headache

Please complete this to see if you may have Chronic Migraines

1(a) How many days in the past month did you spend with a headache/migraine?
(Include ALL days with any headache pain of any kind, even those you didn't feel you needed to take any medication for or only took an over-the-counter medication)

______ day(s)

1(b) How many days in the past month did you spend without ANY headache pain of any kind (headache-free days)?

______ day(s)

1(c) Subtract line B from 31 and enter the number:

______ day(s)

Regarding question 1 (a) or (c) was the answer 15 or more?

☐ Yes or ☐ No

2 Did any of your headaches/migraines last more than 4 hours, if you did not treat them?

☐ Yes or ☐ No

3 Have you ever been diagnosed as having chronic headaches (including tension-type or chronic sinus headaches)?

☐ Yes or ☐ No

4 Have you ever been diagnosed as having migraines?

☐ Yes or ☐ No

5 Do your headaches/migraines impact your daily life?

☐ Yes or ☐ No

Rate the impact of your headaches/migraines on your daily life:

1 2 3 4 5 6 7 8 9 10
Mild Severe

How many days in the past month have your headaches/migraines severely affected your daily life?

______ day(s)

6 In the past month, did you take anything to treat your headaches/migraines?

☐ Yes or ☐ No

If "yes," how many days in the past month did you take something to treat your headaches/migraines (including over-the-counter drugs, prescription medication and/or vitamins/herbal remedies)?

______ day(s)

Please list what you have taken:

____

____

____

____

☐ Check here if you answered "Yes" to both questions 1 and 2 and at least one of the other questions.

Patient Name: ______________________

Patient Name: ________________________ **D.O.B:** ____________ **Date:** ______________

Adult MIDAS (18 years of age and older)

The MIDAS (migraine disability assessment) questionnaire was put together to help you measure the impact your headaches have on your life ***over the last 3 months*** and to communicate this more effectively. The best way to this is by counting the numbers of days of your life which are affected by Headaches.

INSTRUCTIONS • Please answers the following questions about ***ALL your headaches you have had over the last 3 months.*** Select your answer in the box next to each question. If a single headache affects more than one area of your life (e.g., work and family life) it is counted more than once. Select zero if you did not have the activity in the last 3 months. There are no "right" or "wrong" answers so please put down your best guess.

For questions 1 and 2, **work or school** means paid work or education if you are a student at school or college. For Questions 3 and 4, **household work** means activities such as housework, home repairs and maintenance, shopping as well as caring for children and relatives.

---

1. On how many days in the last 3 months did you miss work or school because your headaches?

☐

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches?
(Do not include days you counted in question 1 where you missed work or school.)

☐

3. On how many days in the last 3 months did you not do household work because of your headaches?

☐

4. How many days in the last three months was your productivity in household work reduced by half of more because of your headaches?
(Do not include days you counted in question 3 where you did not do household work.)

☐

Patient Name: ________________________ D.O.B: _________

5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

☐

Enter the total number of days you entered in questions 1-5. This is your MIDAS level of disability.

☐ **Total**

0 to 5 - MIDAS Grade I, *Little or no disability*

6 to 10 - MIDAS Grade II, *Mild disability*

11 to 20 - MIDAS Grade III, *Moderate disability*

21+ - MIDAS Grade IV, *Severe disability*

That Your Physician will need to know about your headache:

A. On how many days in the last 3 months did you have a headache?
(If a headache lasted more than 1 day, count each day.)

☐

B. On a scale of 0 - 10, on average how painful were these headaches?
(Where 0 = no pain at all and 10 = pain as bad as it can be.)

☐