NEW PATIENT DEMOGRAPHIC FORM

Larissa Lempert, MD
50 Court St, Ste 511
Brooklyn, NY 11201-4848
T: (718) 874-0046 | F: (347) 586-0036

Last Name _____ First Name _____ Marital Status _____

Address _____ Apt. _____ City _____ State _____ Zip _____

SS# _____ Date of birth _____ Age _____ Sex ☐ Female ☐ Male

Home Phone _____ Cell Phone _____ Work Phone _____ Ext. _____

Email Address _____

Employer _____ Work status: ☐ Full ☐ Part- time ☐ Retired ☐ Unemployed

Primary Doctor _____ Address _____ Phone _____

In the event of an EMERGENCY who would you like for us to contact? Name _____

Relationship _____ Phone _____

SOCIAL HISTORY

☐ Smoking ☐ Alcohol ☐ Drugs ☐ Vitamins / Supplements
☐ Right handed ☐ Left handed

MEDICAL HISTORY

Do you have, or have you had any of the following? (check all that apply)

☐ Diabetes
☐ High blood pressure
☐ High Cholesterol
☐ Heart disease
☐ Headaches
☐ Cancer
☐ Stroke
☐ Dizziness/Fainting
☐ Stress/ Fatigue
☐ Seizures
☐ Kidney disease
☐ Liver disease
☐ Tested Positive for HIV
☐ Hepatitis A/B/C
☐ Difficulty Concentrating
☐ Surgeries or/and Injuries
☐ Memory problems
☐ Sleep disturbances

Allergy to medications ☐ Yes ☐ No

(If yes, please list these medications) _____

_____

_____

_____

Are you presently taking Medications? ☐ Yes ☐ No (If yes, please list what medications and for what condition)

_____

_____

_____

_____

Please indicate if the following test/s been done this year:

☐ MRI ☐ Nerve conduction study ☐ EMG ☐ MRA ☐ EEG ☐ CT ☐ Sleep study ☐ X-Ray

Patient's Signature _____ Date _____