Stony Brook Medicine
University Physicians

Stony Brook Orthopaedic Associates **Adult New Patient Form**

Patient Name: _____DOB_____
Age: _____ Sex: □ Male □ Female Height: _____ Weight: _____

Who referred you to us:_____
Primary Care Doctor:_____

Reason for today's visit: _____
Location of problem: _____
When did the problem start: _____
Please rate the pain:

What treatments have you had for the problem? _____

Past Medical History

Any major illnesses? □ No □ Yes _____
Previous operations? □ No □ Yes _____
Current medications? □ No □ Yes _____
Allergies to medicine? □ No □ Yes _____

Family History

Parent's ages: _____ Medical Problems: _____
Sibling's ages: _____ Medical Problems: _____

Social History

Occupation: _____
Tobacco use? □ No □ Yes Age started: _____ Age quit:_____
Favorite Activities: _____

Review of Systems (check all that apply)

□ Fever	□ Difficulty breathing	□ Urinary problems	□ Eczema
□ Weight changes	□ Palpitations	□ Bleeding disorders	□ Numbness
□ Headaches	□ Nausea/Vomiting	□ Diabetes	□ Depression

Patient Signature: _____ Date: _____
Best contact phone number: _____
E-Mail: _____