Stony Brook Medicine
University Physicians
Stony Brook Orthopaedic Associates

Patient Questionnaire: **Dr. Nicholas Divaris** Visit Date: _____

Name: _____ _____ DOB: _____
Last First

Address: _____

Home phone: _____ Cell: _____ Work: _____

Occupation: _____Retired:☐Yes☐No / Disabled:☐Yes☐No **Email:** _____

Primary care doctor's name, phone and fax # _____
Summary of today's visit sent to your medical doctor: Include doctor's **fax** number ☐ Yes ☐ No

Injuries: _____
Date of injury:_____ Did injury occur at work: __ Are you currently working:___ Date stopped working:_____

If yes, **Worker's Compensation Information is needed:** Carrier Case #: _____
Adjuster Name: _____ Phone: _____ Fax: _____
Insurance Carrier Name & Address: _____
Employer Name & Address: _____

Is current problem a result of a Motor Vehicle Accident? ☐ Yes or ☐ No Date of Accident:_____
No Fault Insurance Name & Claim#: _____

Health Insurance Company & ID#: _____ Plan: _____ Group: _____
Insurance address:_____ Phone: _____
Subscriber name: _____ Relationship to patient: _____

Medical History: Description of present problem: _____

Allergies: _____

Past medical history: _____
Please include any history of bleeding problems, blood clots or DVT, diabetes, kidney problems, heart disease, cancer, reaction's to anesthesia.

Operations: _____

Medications: _____

Social history: _____
Currently smoke tobacco: _____How many years: ____ When did you start:_____ When did you quit:_____
Use of other nicotine or tobacco products: _____
Currently drink alcohol: _____ How much per day: _____ History of alcohol problem: _____
Recreational drug use: _____ Type and frequency: _____
Past recreational drug use: _____

Patient's Signature: _____ Physician's Signature: _____

If you would like to rate the staff after your office visit please give your email address to the front desk and a press ganey survey will be emailed to you. Or you can ask the front desk for a "star card" to fill out. Thank you.