Stony Brook Medicine

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PATIENT LABEL HERE

EXISTING PATIENT INTAKE FORM

PLEASE CIRCLE OR WRITE IN RESPONSE

PATIENT NAME _____ DOB: _____ TODAY'S DATE: _____

HOME PHONE NUMBER_____ CELL PHONE NUMBER_____

PATIENT SEEN AT THE REQUEST OF:

REFERRING PHYSICIAN: _____

PREVIOUS IMAGING: ☐ **XRAY** ☐ **MRI** ☐ **CT SCAN** ☐ **PET/CT** ☐ **BONE SCAN** ☐ **ULTRA SOUND**

FACILITY WHERE IMAGING COMPLETE: _____
NAME ADDRESS PHONE

PROBLEM: _____

DESCRIBE CHANGES OVER TIME SINCE THE LAST OFFICE VISIT: _____

_____

LOCATION OF PROBLEM: ☐ Left ☐ Right ☐ Both || ☐ Arm ☐ Leg ☐ Other_____

SIZE: PIN TIP – PEA – MARBLE – GOLF BALL – TENNIS BALL – BASEBALL – SOFTBALL – BIGGER

IS IT GROWING: YES | NO

CHARACTER/QUALITY: SHARP – ACHING – BURNING – TIGHT – STIFF

PAIN SCORE AT REST: (NO PAIN) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (WORST PAIN IMAGINABLE)

PAIN SCORE WITH ACTIVITY: (NO PAIN) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (WORST PAIN IMAGINABLE)

WHAT INCREASES THE PAIN? REST – WALKING – STAIRS – SITTING – PIVOT – TWIST – RUN

DOES IT RADIATE? YES | NO WHERE? _____ **NIGHT PAIN?** YES | NO

WHAT MEDICATIONS HAVE YOU TRIED? _____

WHAT ALLEVIATES IT? _____ **ACTIVITIES GIVEN UP:** _____

LIST ANY CHANGES IN YOUR MEDICAL HISTORY THAT WE SHOULD NOTE.

PAST MEDICAL HISTORY: NONE OR LIST _____

_____

ANY MEDICINE CHANGES: NONE OR LIST_____

_____

REVIEW OF SYSTEMS:

ANY FEVER/ CHILLS? YES | NO **ANY MASSIVE WEIGHT LOSS?** YES | NO

ANY HISTORY OF SKIN INFECTIONS/CELLULITIS? YES | NO **ANY OTHER JOINTS HURTING?** YES | NO

ANY BLEEDING TENDENCIES? YES | NO **ANY HISTORY OF BLOOD CLOTS SUCH AS DVT/PE?** YES | NO

ARE YOU ON ANY BLOOD THINNERS, COUMADIN/WARFARIN/PLAVIX/XARELTO/ELIQUIS? YES | NO

ANY HISTORY OF BISPHOSPHONATE MEDICATION? YES | NO **ANY SHORTNESS OF BREATH?** YES | NO

ANY WEAKNESS/NUMBNESS OF EXTREMITY YES | NO **ANY NEW ANXIETY/DEPRESSION?** YES | NO

ANY BOWEL INCONTINENCE? YES | NO **ANY RECENT BLADDER INFECTIONS?** YES | NO

ANY NEW ALLERGIES? YES | NO

EVER BEEN ON ANY IMMUNOSUPPRESSIVE MEDICATIONS OR RHEUMATOID ARTHRITIS MEDICATIONS SUCH AS PREDNISONE, METHOTREXATE, HUMIRA? YES | NO

ALL SYSTEMS REVIEWED & OTHERWISE NEGATIVE [ ]

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONNAIRE,
IT WILL HELP US TAKE BETTER CARE OF YOU TODAY.

_____ _____ _____ _____

PATIENT / GUARDIAN SIGNATURE DATE PHYSICIAN / PA SIGNATURE DATE

(I HAVE PERSONALLY REVIEWED THIS INTAKE FORM ON THE DATE OF SERVICE LISTED)