Stony Brook Medicine

FAZEL KHAN, MD
HALEY RIORDAN, PA

Patient Label Here

PATIENT NAME:_____**DOB:**_____**GENDER:**_____**TODAY'S DATE:** _____
HOME PHONE #:_____**WORK PHONE #:**_____ **CELL PHONE #:**_____
STREET ADDRESS/CITY/STATE/ZIP: _____
PRIMARY RESIDENCE □ PRIVATE HOME □ APARTMENT □ LIVING ALONE □ NURSING HOME □ SHELTER □ OTHER _____
EMERGENCY CONTACT:_____**PHONE:**_____
WHO WILL ASSIST YOU IN YOUR CARE: □ SPOUSE □ FAMILY MEMBER □ FRIEND □ SELF □ OTHER_____
DO OTHERS DEPEND ON YOU FOR THEIR CARE? □ YES □ NO

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PRIMARY CARE PHYSICIAN: _____
NAME ADDRESS PHONE

REFERRING PHYSICIAN: _____
NAME ADDRESS PHONE

PREVIOUS IMAGING: ☐ **XRAY** ☐ **MRI** ☐ **CT SCAN** ☐ **PET/CT** ☐ **BONE SCAN** ☐ **ULTRA SOUND**
FACILITY WHERE IMAGING COMPLETE: _____
PRIMARY COMPLAINT: WHAT PROBLEM ARE YOU SEEING THE DOCTOR FOR TODAY? _____
_____
WHEN DID THIS PROBLEM BEGIN? _____ **HOW DID THIS PROBLEM BEGIN?** _____
_____
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)
IF THERE IS PAIN, WHAT INCREASES THE PAIN? REST – WALKING – STAIRS – SITTING – PIVOT – TWIST – RUN
DOES IT RADIATE? YES | NO WHERE? _____
WHAT MEDICATIONS HAVE YOU TRIED? _____
WHAT ALLEVIATES IT? _____ **ACTIVITIES GIVEN UP:** _____
NIGHT PAIN? YES | NO

PAST MEDICAL HISTORY:

MEDICAL PROBLEMS: _____
_____
_____
PAST SURGICAL HISTORY: _____
_____
CURRENT MEDICATIONS: (INCLUDE DOSES AND FREQUENCY): _____
_____
_____
ALLERGIES: _____
FAMILY MEDICAL HISTORY: _____
_____
SOCIAL HISTORY: **MARITAL STATUS:** MARRIED – DIVORCED – WIDOWED – SINGLE
EMPLOYED/IN SCHOOL: CURRENT | RETIRED | OTHER: _____ **OCCUPATION/GRADE:** _____
TOBACCO: CURRENT | PREVIOUS | NEVER, _____ (PACKS/DAY) FOR _____ YEARS
ALCOHOL: NEVER | RARELY | OCCASIONALLY | DAILY
RECREATIONAL/ILLICIT DRUG USE: YES | NO, **TYPES:** _____

PLEASE FLIP TO CONTINUE ON THE NEXT PAGE

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REVIEW OF SYSTEMS: IF YOU CHECK YES TO ANY QUESTION, PLEASE GIVE A BRIEF EXPLANATION

Y N CONSTITUTIONAL
- □ □ FEVER, SWEATS, CHILLS _____
- □ □ FATIGUE, ANOREXIA _____
- □ □ SIGNIFICANT WEIGHT CHANGE _____
- □ □ PROBLEMS WITH ANESTHESIA _____

Y N EYES/VISION
- □ □ DRY EYES/EYE IRRITATION _____
- □ □ CHANGES IN VISION _____

Y N EARS/NOSE/THROAT
- □ □ EARACHES _____
- □ □ NOSE/SINUS PROBLEMS/NOSE BLEEDS _____
- □ □ SEASONAL ALLERGIES _____
- □ □ DRY MOUTH/SORES IN MOUTH _____
- □ □ BLEEDING GUMS _____
- □ □ SORE THROAT _____

Y N RESPIRATORY
- □ □ SHORTNESS OF BREATH _____
- □ □ COUGH _____
- □ □ PHLEGM/MUCUS _____
- □ □ SNORING _____
- □ □ HISTORY OF ASTHMA _____

Y N CARDIOVASCULAR
- □ □ PALPITATIONS/CHEST PAIN/DISCOMFORT _____
- □ □ CAD/ MI _____
- □ □ SWELLING OF THE ARMS _____
- □ □ BRUISE EASILY _____

Y N GASTROINTESTINAL
- □ □ HEARTBURN/INDIGESTION/GERD _____
- □ □ NAUSEA/VOMITING _____
- □ □ ABDOMINAL/STOMACH PAIN _____
- □ □ JAUNDICE/HEPATITIS _____
- □ □ CHANGES IN STOOL SIZE _____
- □ □ DIARRHEA/CONSTIPATION _____
- □ □ RECTAL BLEEDING _____
- □ □ FECAL INCONTINENCE _____

Y N GENITOURINARY
- □ □ FREQUENT/PAINFUL URINATION _____
- □ □ NIGHT TIME URINATION _____
- □ □ ABNORMAL VAGINAL BLEEDING/DISCHARGE _____
- □ □ IRREGULAR PERIODS _____

Y N MUSCULOSKELETAL
- □ □ HISTORY OF BACK PROBLEMS _____
- □ □ MUSCLE ACHES/ARTHRITIS _____
- □ □ H/O BISPHOSPHONATE USE _____

Y N INTEGUMENTARY
- □ □ SKIN RASHES _____
- □ □ CELLULITIS _____

Y N NEUROLOGIC
- □ □ HEADACHES _____
- □ □ WEAKNESS/NUMBNESS _____
- □ □ SEIZURES _____
- □ □ DIZZINESS/FAINTNESS _____
- □ □ DIFFICULTY SWALLOWING _____

Y N PSYCHOLOGIC
- □ □ ANXIETY/DEPRESSION _____
- □ □ SLEEP PROBLEMS _____

Y N HEMATOLOGIC/LYMPHATIC
- □ □ BLEEDING TENDENCIES _____
- □ □ H/O DVT OR PE _____
- □ □ LYMPHEDEMA _____
- □ □ USE OF BLOOD THINNERS _____

Y N ENDOCRINE
- □ □ H/O DIABETES _____
- □ □ H/O THYROID DISEASE _____
- □ □ VITAMIN D DEFICIENCY _____

OTHER SYMPTOMS: _____

[ ] ALL SYSTEMS REVIEWED AND OTHERWISE NEGATIVE

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

FACILITY WHERE IMAGING COMPLETE: _____

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