STONY BROOK ORTHOPAEDIC ASSOCIATES
JOINT REPLACEMENT CENTER

Stony Brook Medicine

FAZEL KHAN, MD
HALEY RIORDAN, PA

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: _____
NAME ADDRESS PHONE

PROBLEM: _____ Height: _____

DESCRIBE CHANGES OVER TIME SINCE THE LAST OFFICE VISIT: _____ Weight: _____

_____

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? Y/N WHERE? _____ **DOES IT CATCH OR LOCK?** Y/N WHEN? _____ FREQUENCY _____
DOES IS BUCKLE? Y/N WHEN? _____ FREQUENCY _____
WHAT MEDICATIONS HAVE YOU TRIED? _____
WHAT ALLEVIATES IT? _____ **ACTIVITIES GIVEN UP:** _____

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***DISTANCE WALKED*:** unlimited | 1 mile | 6 blocks | 2-3 blocks | indoors only | unable to walk

***SUPPORT NEEDED*:** none | 1 cane for long walks | 1 cane full time | 1 crutch | 2 canes | 2 crutches | unable

***LIMP*:** none | slight | moderate | severe

***SITTING*:** comfortably in any chair 1 hour | comfortable high chair 1 hour | unable to sit comfortably

***STAIRS*:** step over step unsupported | need banister for support | one step at a time difficult | unable

***SOCKS/TIES SHOES*:** with ease | with difficulty | unable

***TRANSPORTATION*:** get in and out independently | significant difficulty

***ARISE FROM CHAIR*:** with arms | without arms

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

PAST MEDICAL HISTORY: NONE OR LIST _____

ANY MEDICINE CHANGES: NONE OR LIST_____

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WHAT KIND OF CONSERVATIVE TREATMENT TRIED: ☐ **PHYSICAL THERAPY** ☐ **HOME EXERCISES**
☐ **MEDICATION** ☐ **BRACE** ☐ **INJECTIONS** || **HOW LONG TRIED CONSERVATIVE TREATMENT:** _____

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REVIEW OF SYSTEMS:

ANY FEVER/ CHILLS? YES | NO
ANY RECENT WEIGHT LOSS? YES | NO
ANY OTHER JOINTS HURTING? YES | NO
ANY NEW BLEEDING TENDENCIES? YES | NO
ANY RECENT SKIN OR URINARY INFECTIONS? YES | NO
ARE YOU ON ANY BLOOD THINNERS, COUMADIN/WARFARIN/PLAVIX/XARELTO/ELOQUIS? YES | N

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

PLAN: [ ] CORTISONE INJECTION [ ] RIGHT [ ] LEFT [ ] KNEE [ ] HIP
[ ] BOOKED SURGERY

(I HAVE PERSONALLY REVIEWED THIS INTAKE FORM ON THE DATE OF SERVICE LISTED)
[ ] GEL INJECTION [ ] RIGHT [ ] LEFT [ ] KNEE [ ] HIP
[ ] MRI [ ] CT [ ] CONSULT - _____