STONY BROOK ORTHOPAEDIC ASSOCIATES
JOINT REPLACEMENT CENTER

**FAZEL KHAN, MD**
**HALEY RIORDAN, PA**

Stony Brook Medicine

NEW PATIENT INTAKE FORM

***PLEASE CIRCLE OR WRITE IN RESPONSE***

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

HOME PHONE #_____ CELL PHONE #_____ WORK PHONE # _____

ADDRESS: _____
STREET # & NAME OR P.O. BOX CITY STATE ZIP

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PRIMARY CARE PHYSICIAN: _____
NAME ADDRESS PHONE

REFERRING PHYSICIAN: _____
NAME ADDRESS PHONE

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**PROBLEM – BODY PART INJURED:** ☐ **LEFT** ☐ **RIGHT** _____ Height: _____

DESCRIBE THE ONSET/TRAUMA/INJURY _____ Weight: _____

_____

DESCRIBE CHANGES OVER TIME _____

_____

LOCATION OF DISCOMFORT: **HIP:** FRONT– BACK– INNER– OUTER – GROIN
**KNEE:** FRONT – BACK – INNER – OUTER– KNEE CAP **OTHER**: _____

**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? _____
**DOES IT CATCH OR LOCK?** YES | NO WHEN? _____ FREQUENCY _____
**DOES IS BUCKLE?** YES | NO WHEN? _____ FREQUENCY _____
**WHAT MEDICATIONS HAVE YOU TRIED?** _____
**WHAT ALLEVIATES IT?** _____ **ACTIVITIES GIVEN UP:** _____

***DISTANCE CAN WALK*:** 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 | walker | unable
***LIMP*:** none | slight | moderate | severe || ***ARISE FROM CHAIR*:** with arms | without arms
***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

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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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**PAST MEDICAL HISTORY/REVIEW OF SYSTEMS:**

**ANY HISTORY OF BLADDER INFECTIONS?** YES | NO **ANY HISTORY OF TOOTH INFECTIONS?** YES | NO
**ANY HISTORY OF SKIN INFECTIONS/CELLULITIS?** YES | NO **ANY BLEEDING TENDENCIES?** YES | NO
**ANY HISTORY OF BLOOD CLOTS SUCH AS DVT/PE?** YES | NO **LOSING WEIGHT LATELY?** YES | NO
**ARE YOU ON ANY BLOOD THINNERS, COUMADIN/WARFARIN/PLAVIX/XARELTO/ELOQUIS?** YES | NO
**ARE YOU A DIABETIC?** YES | NO **IS YOUR DIABETES WELL-CONTROLLED?** YES | NO **LAST HGB A1C**: ___
**EVEN BEEN ON ANY IMMUNOSUPPRESSIVE MEDICATIONS OR RHEUMATOID ARTHRITIS MEDICATIONS SUCH AS PREDNISONE, METHOTREXATE, HUMIRA?** YES | NO **HISTORY OF HIV OR HEPC?** YES | NO

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**MEDICAL PROBLEMS:** _____

_____

_____

**PAST SURGICAL HISTORY:** _____

_____

**CURRENT MEDICATIONS: (INCLUDE DOSES AND FREQUENCY):** _____

_____

**ALLERGIES:** _____

**FAMILY MEDICAL HISTORY:** _____

_____

**SOCIAL HISTORY: MARITAL STATUS:** MARRIED – DIVORCED – WIDOWED – SINGLE

**OCCUPATION:** _____ **CURRENTLY WORKING?** YES | NO

**TOBACCO:** CURRENT | PREVIOUS | NEVER, _____ (PACKS/DAY) FOR ____ YEARS

**ALCOHOL:** NEVER | RARELY | OCCASIONALLY | DAILY

**RECREATIONAL/ILLICIT DRUG USE:** YES | NO, **TYPES:** _____

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## CHECK ALL THAT APPLY:

ALL SYSTEMS REVIEWD AND OTHERWISE NEGATIVE [ ]

GENERAL
[ ] RECENT WEIGHT CHANGE
[ ] FEVER OR CHILLS
[ ] CANCER
[ ] AIDS/HIV
[ ] PROBLEMS WITH ANESTHESIA

EYE
[ ] VISUAL CHANGE

EAR-NOSE-THROAT
[ ] HEARING CHANGE
[ ] NOSE BLEEDS
[ ] BLEEDING GUMS
[ ] DENTAL CARIES

RESPIRATORY
[ ] COUGH/SPUTUM
[ ] TUBERCULOSIS
[ ] SHORTNESS OF BREATH
[ ] ASTHMA
[ ] EMPHYSEMA

CARDIOVASCULAR
[ ] HEART ATTACK
[ ] HEART DISEASE
[ ] HIGH BLOOD PRESSURE
[ ] SWELLING OF ANKLES

GASTROINTESTINAL
[ ] DIFFICULTY SWALLOWING
[ ] HEARTBURN/GERD
[ ] ULCER
[ ] HEPATITIS

GENITOURINARY
[ ] URINARY INFECTIONS
[ ] INCONTINENCE

MUSCULOSKELETAL
[ ] BACK ACHE
[ ] OTHER JOINT PAIN
[ ] MUSCLE ACHES
[ ] ARTHRITIS
[ ] GOUT

NEUROLOGIC
[ ] STROKE/TIA
[ ] NUMBNESS
[ ] TINGLING

PSYCHOLOGICAL
[ ] DEPRESSION
[ ] ANXIETY
[ ] SLEEP PROBLEMS

INTEGUMENTARY
[ ] RASH
[ ] CELLULITIS

ENDOCRINE
[ ] DIABETES
[ ] THYROID ILLNESS
[ ] VITAMIN D DEFICIENCY

HEMATOLOGIC/LYMPHATIC
[ ] BLEEDING TENDENCIES
[ ] BLOOD CLOTS
[ ] LYMPHADEMA
[ ] ANEMIA

***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 )

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

[ ] GEL INJECTION [ ] RIGHT [ ] LEFT [ ] KNEE [ ] HIP
[ ] MRI [ ] CT [ ] CONSULT - _____