** **

**Stony Brook University Orthopaedics**

**Patient Follow-Up Information Form**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_TODAY’S DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST FIRST M.I.

WORK/SPORTS STATUS: Full Time / Part Time / Injured / Disabled / Student / Retired / Playing Sports

CURRENT SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SPORTS/OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INCLUDE SCHOOL &GRADE/LEVEL INCLUDE POSITIONS PLAYED

REFERRING PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME ADDRESS PHONE # ***(Do you want a note or letter sent to them? YES/NO)***

COACH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If applicable) NAME ADDRESS PHONE # ***(Do you want a note or letter sent to them? YES / NO)***

ATHLTIC TRAINER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If applicable)  NAMES SCHOOL/TEAM PHONE # ***(Do you want a note or letter sent to them? YES / NO)***

**CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS:**

IS THIS A NEW INJURY THAT YOU HAVE NOT BEEN SEEN FOR BEFORE? YES / NO

BODY PART INJURED: □LEFT □RIGHT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF INJURY/ACCIDENT/ONSET: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CAUSE: SPORTS/WORK/MVA/OTHER

HOW DID THE INJURY OCCUR?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DOES IT EFFECT / BOTHER YOU?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAIN AT REST: (No Pain**) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Worst Pain Imaginable)

PAIN AT ACTIVITY: (No Pain**) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Worst Pain Imaginable)

DOES ANYTHING HELP DECREASE YOUR PAIN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THIS PROBLEM? IMPROVING / SAME / WORSENING / OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU IN PHYSICAL THERAPY? YES / NO , IF YES WHERE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YOU WERE/ARE UNABLE TO WORK/PLAY LIST DATES OF DISABILITY:\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY:**

LIST ANY CHANGES TO YOUR MEDICAL HISTORY SINCE YOUR LAST VISIT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ANY NEW MEDICATIONS SINCE YOUR LAST VISIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PROVIDER NOTES SECTION:

**REVIEW OF SYMPTOMS: (**Check All That Apply)

GENERAL GASTROINTESTINAL GENITOURINARY

[ ] WEIGHT CHANGE [ ] DIFFICULTY SWALLOWING [ ] URINARY INFECTIONS

[ ] FEVER OR CHILLS [ ] JAUDICE [ ]INCONTINENCE

[ ] AIDS/HIV [ ] HEPATITIS [ ] URINARY FREQUENCY

[ ] NIGHT SWEATS [ ] REFLUX [ ] VENERAL DISASE

[ ] BLEEDING [ ] ULCER [ ] MENOPAUSE

[ ] LUMPS OR MASSES CARDIOVASCULAR NEUROLOGIC

[ ] DIZZINESS OR FAINTING [ ] CHEST PAIN [ ] SEIZURES

[ ] DIABETES MELLITUS [ ] HEART DISEASE [ ] NUMBNESS

[ ] THYROID PROBLEM [ ] HIGH BLOOD PRESSURE [ ] WEAKNESS

[ ] CANCER [ ] MITRAL VALVE PROLAPSE PSYCHOLOGICAL

EAR-EYE-NOSE-THROAT [ ] THROMBOHLEBITIS [ ] DEPRESSION

[ ] VISUAL CHANGE RESPIRATORY [ ] BIPOLAR

[ ] HEARING CHANGE [ ] COUGH/SPUTUM [ ] ADD/ADHD

[ ] TINNITUS [ ] TUBERCULOSIS [ ] OTHER

[ ] BLEEDING GUMS [ ] SHORTNESS OF BREATH SKIN

MUSCULOSKELETAL [ ] ASTHMA [ ] ITCHING OR RASH

[ ] BACKACHE [ ] EMPHYSEMA

[ ] JOINT PAIN OTHER ILLNESS :­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] JOINT SWELLING

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE DATE \*\*PHYSICIAN'S SIGNATURE\*\* DATE

(I HAVE REVIEWED AND DISCUSSED THE ABOVE WITH THE PATIENT.)