Stony Brook Medicine

Stony BrookOrthopaedic Associates

Dr. Umar New Patient Intake Form

Date_____ MRN_____

Name_____ DOB_____

Dominant Hand: □ Left Handed □ Right Handed Sex: □ Male or □ Female

Referring Physician: _____

Primary Physician: _____

Occupation: _____

When was the last time you worked? _____

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

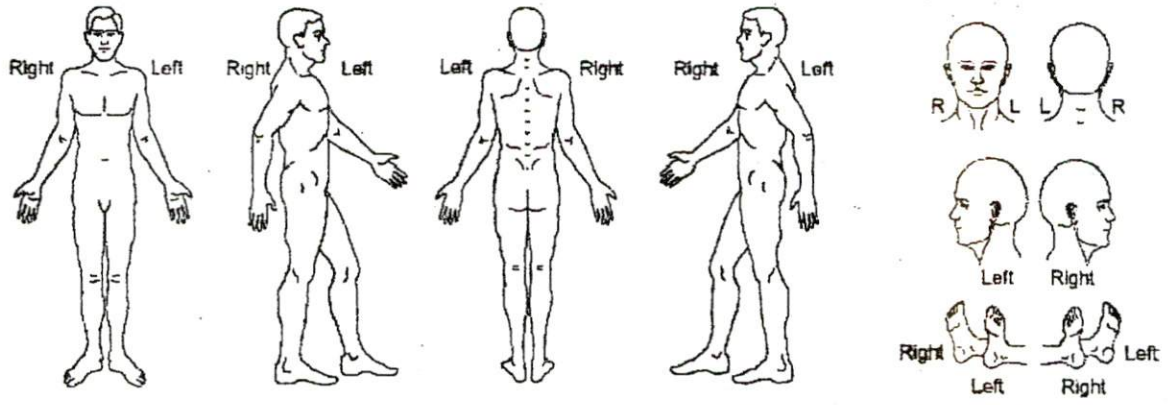
Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Chief Complaint: _____

_____

Where is pain located?



When is your pain at its worst? ☐ Mornings ☐Daytime ☐ Evenings ☐ Middle of the night ☐ Always the same

How often does the pain occur? ☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets_____ The Worst It Gets_____

Does pain radiate? If so where?_____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Does your pain awaken you from sleep? _____

Do you experience weakness in the extremities? _____

Do you experience Bowel/Bladder incontinence? ☐ Yes ☐ No

If yes describe: _____

_____

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Previous Treatments:_____

_____

Social History

Alcohol Use: ☐ Social Use ☐ History of alcoholism ☐ Current alcoholism ☐Never

☐ Daily use of alcohol

Tobacco Use: ☐ Current user ☐ Former user ☐ Never used ☐ Packs per day? _____ ☐

How many years? _____ ☐ Quit Date: _____

Illegal Drug Use: ☐ Denies any illegal drug use ☐ Currently uses illegal drugs

☐ Formerly used illegal drugs (not currently using)

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

Medication Name Allergic Reaction

_____

_____

_____

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

Medication Name Dose Frequency

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgical History

Please list any surgical procedures you have had done in the past including date:

_____ Date? _____

_____ Date? _____

_____ Date? _____

_____ Date? _____

☐ No surgical history.

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Family History

Mark all appropriate diagnoses as they pertain to your first degree relatives:

☐Arthritis	☐Cancer	☐Diabetes
☐Headaches/Migraines	☐High Blood Pressure	☐Kidney Problems
☐Liver Problems	☐Osteoporosis	☐Rheumatoid arthritis
☐Seizures	☐ Stroke	

☐Other Medical Problems:

_____

☐ No family medical history

Medical History

Mark all appropriate diagnoses as they pertain to you:

☐ Cancer – Type _____ ☐ Diabetes – Type_____

☐ Anemia	☐ Coronary Artery Disease	☐ High Blood Pressure
☐ Peripheral Vascular Disease	☐ Heart Attack	☐ Stoke/TIA
☐ Heart Valve Disorders	☐ Asthma	☐ Hyperthyroidism
☐ Hypothyroidism	☐ Urinary Incontinence	☐ Chronic Kidney Disease
☐ GERD (Acid Reflux)	☐ Gastrointestinal Bleeding	☐ Stomach Ulcers
☐ Multiple Sclerosis	☐ Peripheral Neuropathy	☐ Seizures
☐ Depression	☐ Anxiety	☐ Heart Attack
☐ Schizophrenia	☐ Bipolar Disorder	
☐ No medical history		

Signature_____

Opioid Risk Tool (ORT)

Patient Form

Name _____ Date _____

Mark each box that applies		Female	Male
1. Family history of substance abuse	▪ Alcohol ▪ Illegal drugs ▪ Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
2. Personal history of substance abuse	▪ Alcohol ▪ Illegal drugs ▪ Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
3. Age (mark box if 16-45 years)		[ ]	[ ]
4. History of preadolescent sexual abuse		[ ]	[ ]
5. Psychological disease	▪ Attention-deficit/ hyperactivity disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia ▪ Depression	[ ] [ ]	[ ] [ ]

STONY BROOK ORTHOPAEDICS

PATIENT CONTRACT FOR THE LONG-TERM TREATMENT OF NON-MALIGNANT CHRONIC PAIN WITH NARCOTICS

Patient Name: _____ Med. Rec. #: _____

Treatment of non-malignant chronic pain with long-term narcotic therapy is undertaken after all other treatment options have failed. It is important that you understand that there are Federal and State laws which govern the legality of this practice and will require you to fully cooperate with the prescribing physician by following the rules listed below:

1. You will provide us with your old records from prior pain physicians or physicians from whom you received narcotics and any other medications you received for your pain.

2. You will obtain prescriptions for all narcotics and other pain-relieving medications you use from only the physicians in this office. Notify us in advance of acute needs (dental work, surgery).

3. Get all narcotic and any other prescriptions that we write filled at one pharmacy for accurate review.

4. Do not change your dose without prior discussion with your doctor. If you need a stronger dose of medication if your pain worsens, do not increase the amount of pills you take on your own.

5. There will be no refilling of prescriptions by phone. There will be no early refills. The law requires a patient to be evaluated while taking medication to assure quality care.

6. You must obtain the consultations with other specialists as recommended.

7. Not showing for a scheduled appointment shows disregard for the doctor/patient relationship and negatively impacts your treatment. You must call to cancel an appointment and reschedule another one as soon as possible if you cannot come. Medications will not be called in for you. Two no shows will be cause for discharge.

8. Abstain from alcohol and illegal drug use.

9. You may be asked to provide urine or blood specimens for drug testing. Refusal to provide a specimen will result in medication tapering and discontinuation.

10. If there is evidence that you are:

    a. obtaining narcotics from other physicians or multiple pharmacies;
    b. escalating the dose of medications in an uncontrolled fashion without discussion with the prescribing physician;
    c. hoarding narcotic drugs; or
    d. changing a prescription (this is illegal and you can be arrested),

    your narcotic prescription will no longer be renewed by the prescribing physician and you will be tapered off the narcotic treatment.

11. *If you lose your prescription a police report is required. If a mishap occurs such as spilling your medication in the sink, etc., we will renew the medication once. If any of the above occur a second time your prescription will not be renewed until you are due. It is your responsibility to make sure this does not occur.*

12. It is your responsibility to account for your medications taken and know ahead of time that

you will need a refill by a specific date. Make your appointment for this at your office visit. Scheduled appointments are necessary to assure quality of care to our patients.

NOT COMPLYING WITH CONTRACT RULES WILL ACTIVATE YOUR DISCHARGE!

WARNINGS:

The use of narcotic drugs may cause physical and psychological dependence. It may be very difficult for you to stop taking these drugs. The chronic use of these drugs is also associated with developing tolerance to their effects and the usual doses may become ineffective over time.

The use of narcotic drugs will limit your abilities to perform certain skilled tasks such as driving or operating machinery, and attempting to do so under the influence of medication may lead to physical harm to you and to others.

Female patients of childbearing age should consider that if they become pregnant while on narcotic therapy, they may have children who are physically depending on narcotic drugs at birth.

Other side effects include constipation and you may need to take a laxative to maintain regular bowel movements.

* * * * *

I have read the above contract and warnings. I have discussed the above statement with my physician, Dr. _____ and he/she has answered all questions that I have to my satisfaction. I understand and agree to follow the rules as stated above for the long-term use of narcotic drugs for my pain problem.

Pharmacy I will use _____ Phone _____

Address _____

_____ _____

Patient Name (please print) Patient Signature

_____ _____

Witness Name (please print) Witness Signature

Date _____

Stony Brook Medicine

Department of Radiology

Hospital Radiology Services

Dear Patient,

Thank you for choosing Stony Brook Medicine for your care and treatment. Please be advised that the Radiological Services provided here during this office visit are a Stony Brook University Hospital Service.

If you are having x-rays taken as part of today's visit, your insurance carrier will be billed separately for the professional and technical portions of the x-ray as a Hospital Service. The technical portion of the bill covers the costs of equipment, supplies, the radiology technician and other hospital personnel. The professional portion covers the personal professional services of the radiologist (physician) who will interpret the radiological test.

In addition to your usual co-payment for your doctor office visit, you may incur another co-payment for the hospital based x-ray services or based on your insurance carrier, the fees could be applied towards your Hospital Deductible.

Please call your insurance carrier to determine your benefits related to outpatient hospital diagnostic services.

Please acknowledge that you have read the above statement by signing below:

_____ SIGNATURE

_____ NAME OF PATIENT

_____ PRINT NAME

_____ DATE OF SERVICE

HSC-L4-092, STONY BROOK, NEW YORK 11794-8420 TEL: 631-444-2420 FAX: 631-444-3443