Stony Brook Medicine

FOLLOW-UP PATIENT HISTORY

TODAY'S DATE _____

NAME _____ **NICKNAME**_____ **AGE**_____

DATE OF BIRTH _____ **HEIGHT** _____ft _____in **WEIGHT** _____lbs **BMI** _____

IS THIS A NEW INJURY (IF YES, HOW)? ☐ Yes ☐ No _____

ARE YOU PRESENTLY WORKING? ☐ Yes ☐ No **DATE(S) OUT OF WORK** _____

WHERE IS THE PAIN? _____

PAIN LEVEL (1-10)? _____ **HOW MUCH BETTER SINCE LAST VISIT?** _____%

Pain at night? ☐ Y ☐ N Difficulty Sleeping? ☐ Y ☐ N

WHAT MAKES IT BETTER? _____

WHAT MAKES IT WORSE? _____

WHAT MEDICATIONS ARE YOU TAKING FOR PAIN (LIST ALL)? ☐ **NO CHANGE IN MEDS SINCE LAST VISITS**

_____

ANY NEW SYMPTOMS SINCE PRIOR VISIT? ☐ **Y** ☐ **N**

ANY NEW TESTS, EMERGENCY ROOM VISIT(S), OR HOSPITALIZATIONS SINCE LAST VISIT? ☐ **Y** ☐ **N**

ARE YOU TAKING ANY BLOOD THINNERS? ☐ **Y** ☐ **N**

Weight Loss	Weight Gain
Fevers	Vision Changes
Shortness of Breath	Cough
Wheezing	Chest Pain
Irregular Heart Rate	Swelling
Abdominal Pain	Rectal Bleeding
Painful Urination	Difficulty Urinating
Urinary Tract Infections	Tingling
Numbness	

HAVE YOU PARTICIPATED IN PHYSICAL THERAPY?

☐ **Y** ☐ **N** **IF YES, LAST SESSION** _____

ANY CHANGES IN MEDICAL HISTORY SINCE LAST VISIT?

☐ **Y** ☐ **N** _____

_____

STONY BROOK Orthopaedic Associates
(631) 444-4233