Stony Brook
Orthopaedic Associates

Jeffrery Muhlrad, MD Revist Sheet

TODAY'S DATE: _____

PATIENT NAME: _____ DOB: _____

PHONE (HOME) _____ (WORK) _____ (CELL) _____

IS THIS A NEW INJURY? YES ____ NO____

IF YES HOW DID IT OCCUR? _____ _____

ARE YOU PRESENTLY WORKING? YES____ NO ____ DATE(S) OUT OF WORK? _____ TO _____

HAS YOUR INSURANCE CHANGED SINCE YOUR LAST VISIT? ____YES ____ NO

IF YES, WHAT IS YOUR NEW INSURANCE? _____

LIST IN ORDER OF IMPORTANCE YOUR MAIN COMPLAINTS:

1) _____

2) _____

HOW DO YOU FEEL? _____

DO YOU HAVE PAIN? YES___ NO___ INTENSITY SCALE: LOWEST 0 1 2 3 4 5 6 7 8 9 10 HIGHEST

WHERE IS THE LOCATION OF YOUR PAIN? _____

HOW LONG HAVE YOU BEEN IN PAIN? _____

DOES ANYTHING YOU DO HELP DECREASE YOUR PAIN? _____

DO YOU TAKE MEDICATIONS OR ANTI-INFLAMMATORIES FOR YOUR PAIN? ____YES ____ NO

IF YES, WHAT MEDICATIONS ARE YOU TAKING? _____

HOW LONG HAVE YOU BEEN TAKING THEM? _____

HAVE YOU PARTICIPATED IN ANY PHYSICAL THERAPY? _____.

IF YES, FOR HOW LONG? _____.

SINCE YOUR LAST VISIT, HAVE YOU HAD A DVT (Blood Clot)? YES_____ NO_____

IF YES, WHEN DID IT HAPPEN? _____

IF YES, ARE YOU ON ANY ANTICOAGULANT MEDICATION? YES_____ NO_____

IF YES, WHICH MEDICATION(s) ARE YOU TAKING? _____

SINCE YOUR LAST VISIT, HAVE YOU HAD A PACEMAKER PLACED? YES_____ NO_____

IF YES, WHEN WAS IT PLACED? _____

SINCE YOUR LAST VISIT, HAVE YOU HAD A DEFIBRILLATOR PLACED? YES_____ NO_____

IF YES, WHEN WAS IT PLACED? _____

LIST ALL CURRENT MEDICATIONS:

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

IF MORE ROOM IS NEEDED PLEASE TURN PAGE OVER FOR MORE SPACE

_____ _____

PATIENT SIGNATURE DATE *****PHYSICIAN'S SIGNATURE DATE

_____ I HAVE REVIEWED AND DISCUSSED THE ABOVE WITH THE PATIENT*****