Stony Brook
Orthopaedic Associates

REVISIT SHEET

TODAY'S DATE: _____

PATIENT NAME: _____DOB: _____

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

IS THIS A NEW INJURY?: [ ] YES [ ] NO If yes, when and how occurred? _____

_____

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? _____. If yes, WHAT KIND AND FOR HOW LONG? _____

HAVE YOU EVER HAD ANY BLOOD CLOTS? _____ARE YOU ON BLOOD THINNERS? _____
DOES ANY FAMILY MEMBER HAVE A HISTORY OF HAVING A BLOOD CLOT? _____

LIST CURRENT MEDICATIONS:

1) _____ 3) _____ 5) _____

2) _____ 4) _____ 6) _____

Patient/Family Education done? [ ] YES [ ] NO Topic:_____

_____ _____

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

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

REVISED 06/16