Stony Brook Medicine
University Physicians
Stony Brook Orthopaedic Associates

Adult Patient Questionnaire: **Jeffrey Muhlrad, MD**

Visit Date: _____

NAME: _____ _____ MRN#_____
Last First for office use only

PHONE (HOME) _____ (WORK) _____ (CELL) _____
DOB: _____ Are you: Right handed □ Left Handed □
Who referred you to our office? Please circle one: MD NP PA PT ATC Coach
Name: _____
Address:_____
Would you like a copy of today's note sent to the referral source? Yes□ No□
Do you have a Family Doctor (PCP)? Yes□ No□ If yes, please note:
Doctor's Name: _____
Doctor's Address:_____
_____
Are you: Married□ Single□ Divorced□ Widowed□ Other_____
Are you currently employed? Yes□ No□ Occupation: _____

Are you retired? Yes□ No□ Are you disabled? Yes□ No□
Is the current problem a workplace injury? Yes□ No□ If yes, date injury occurred _____
If yes, Worker's Compensation Information:
Date of Injury: _____Carrier Case#:_____
Is the current problem the result of a motor vehicle accident? Yes□ No□
If you have been unable to work, please give the first date of disability: _____
Is there a lawsuit pending? Yes□ No□
Are you a student? Yes□ No□ If yes, what school _____what grade_____
Do you play sports? Yes□ No□ If yes, what sport(s)/position(s)_____
Chief Complaint: _____
_____

Do you have any pain at rest? Yes□ No□
Pain Intensity Scale: 0□ 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□
Do you have any pain with activity? Yes□ No□
Pain Intensity Scale: 0□ 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□
When did the problem start? _____
How did the problem start? _____
_____
Are your symptoms currently: Getting better □Getting worse □ Staying the same□
Describe your treatment so far: _____

Do you currently have a DVT (Blood Clot)? Yes_____ No_____
Have you ever had a DVT (Blood Clot)? Yes_____ No_____
If yes, where was it located_____?
If yes, when did you have it? _____
Are you still being treated for it Yes_____ No_____
Are you currently on any anticoagulant medication? Yes____ No____
If yes which medication(s) are you taking? _____
Do you have a Pacemaker? Yes _____ No_____ When was it placed? _____
Do you have a Defibrillator? Yes _____ No_____ When was it placed? _____

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MEDICAL HISTORY:

Operations:_____

_____

Medical Illnesses:_____

_____

Drug Allergies:_____

Latex Allergy: Yes□ No□ Metal Allergy: Yes□ No□ Contrast Allergy: Yes□ No□

List all medications taken regularly:_____

_____

_____

Childhood Arthritis Yes□ No□

Other: _____

FAMILY HISTORY:

Does anyone in your family (blood relatives) have the following:

Diabetes Mellitus	Yes□ No□	Bleeding Disorders	Yes□ No□
Heart Disease	Yes□ No□	Reactions to Anesthesia	Yes□ No□
TB (tuberculosis)	Yes□ No□	Cancer	Yes□ No□
Hip dislocation	Yes□ No□	Genetic disorder	Yes□ No□
Multiple sclerosis	Yes□ No□	Scoliosis	Yes□ No□

SOCIAL HISTORY:

Do you smoke? Yes□ No□ If yes, how many packs a day?_____

How many years? _____

Did you ever smoke? Yes□ No□ If yes, how many packs a day?_____

How many years? _____ When did you quit? _____

Do you drink alcohol? Yes□ No□ If yes, how much per week? _____

Do you use recreational drugs? Yes□ No□ If yes, list drug(s) and frequency _____

_____

What are your hobbies, recreational activities, sports? _____

_____

REVIEW OF SYSTEMS: (check all that apply)

General-
- □ Weight loss or gain
- □ Fatigue
- □ Fever or chills
- □ Weakness
- □ Trouble sleeping

Skin-
- □ Rashes
- □ Lumps
- □ Itching
- □ Dryness
- □ Color changes
- □ Hair and nail changes

Respiratory-
- □ Cough
- □ Sputum
- □ Shortness of breath
- □ Asthma
- □ Sleep apnea
- □ Swelling

Cardiovascular-
- □ Chest pain or discomfort
- □ Tightness
- □ Palpitations
- □ Shortness of breath with activity

Gastrointestinal-
- □ Swallowing difficulties
- □ Heartburn
- □ Change in appetite
- □ Nausea
- □ Change in bowel habits
- □ Rectal bleeding
- □ Constipation
- □ Diarrhea
- □Yellow eyes or skin

Urinary-
- □ Frequency
- □ Urgency
- □ Burning or pain
- □ Incontinence
- □ Change in urinary strength

Vascular-
- □ Calf pain with walking
- □ Leg cramping
- □ Deep Vein Thrombosis

Musculoskeletal-
- □ Muscle or joint pain
- □ Stiffness
- □ Back pain
- □ Redness of joints
- □ Swelling of joints
- □ Trauma

Neurologic-
- □ Dizziness
- □ Fainting
- □ Seizures
- □ Weakness
- □ Numbness
- □ Tingling

Hematologic-
- □ Ease of bruising/bleeding
- □ HIV
- □ Hepatitis C

Patient Signature: **Date:**

Physician Signature: **Date**