University Hand Center at Stony Brook

Stony Brook Medicine

Dr. Samantha Muhlrad
New Patient Intake Form

TODAY'S DATE _____

PATIENT NAME _____ DOB: _____ GENDER: M / F
HEIGHT _____WEIGHT_____ DOMINANT HAND: LEFT RIGHT
HOME PHONE _____ CELL PHONE _____
ADDRESS: _____
PHARMACY NAME & PHONE: _____
PRIMARY CARE/ REFERRING PHYSICIAN:
_____
NAME ADDRESS PHONE
REASON FOR TODAY'S VISIT _____
DATE OF INJURY/ONSET_____

IS THIS A WORK OR MOTOR VEHICLE RELATED INJURY: YES NO
ARE YOU CURRENTLY WORKING: YES NO
OCCUPATION:

PAIN SCALE: (NO PAIN) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (SEVERE PAIN)
WHAT TREATMENTS HAVE YOU TRIED?

PAST MEDICAL HISTORY: (CHECK ALL THAT APPLY)

☐ FEVER,/CHILLS ☐ Depression/Anxiety ☐Urinary Frequency ☐ Eczema/Skin rashes

☐ Weight changes ☐Palpitations/Chest pain ☐ Bleeding Disorder ☐ Numbness/Tingling

☐ Headaches ☐ Nausea/Vomiting ☐ Diabetes ☐ Difficulty breathing, SOB

☐ Vision changes ☐ Thyroid Disorders

ANY MAJOR ILLNESSES: YES | NO _____
PREVIOUS OPERATIONS: YES | NO _____
CURRENT MEDICATIONS: _____
ALLERGIES TO MEDICINE: _____
REACTION TO ANESTHESIA: YES NO
INFLAMMATORY DISEASES: (E.G.: LUPUS, RA, GOUT) _____
BLEEDING DISORDER: YES NO
SOCIAL HISTORY: TOBACCO ALCOHOL ILLICIT DRUGS FREQUENCY _____

PATIENT SIGNATURE: _____

PARENT /GUARDIAN SIGNATURE: _____