STONY BROOK ORTHOPAEDIC ASSOCIATES

Date:___/___/___

New Patient Questionnaire-Podiatry ☐ Dr. Jason Behar ☐ Dr. Lisa Riccio

Name: _____ Date of Birth: __/____/___ ☐ Male ☐ Female
Street: _____ City: _____ State: ____ Zip: _____
Home #: _____ Cell #: _____ Other #: _____
Email: _____ Social Security#: ___/___/___
Emergency Contact Name: _____ Phone #: _____

Primary Insurance: _____ Are you the insured? ☐ Yes ☐ No
Subscriber name: _____ Relationship to Insured? ☐ Spouse ☐ Child ☐ Self ☐ Other
ID#: _____ Group #: _____ Date of birth: ____/___/____
Is this insurance from your employer? ☐ Yes ☐ No Employer: _____
Is a referral required? ☐ Yes ☐ No
Secondary Insurance: _____ Are you the insured? ☐ Yes ☐ No
Subscriber Name: _____ Relationship to insured? ☐ Spouse ☐ Child ☐ Self ☐ Other
ID#: _____ Group#: _____ Date of birth: ____/___/____
Is this insurance from your employer? ☐ Yes ☐ No Employer: _____
Is a referral required? ☐ Yes ☐ No

Primary Care Physician: _____ Phone #: _____
Street: _____ City: _____ State: _____ Zip: _____
Please let us know who referred you to us:
Referring Physician: _____ Phone #: _____
Street: _____ City: _____ State: _____ Zip: _____

Do you have Diabetes? ☐ Yes ☐ No
If yes, please fill in the following information.
When were you diagnosed with Diabetes: ____/____/____
Treating Physician: _____ Phone #: _____
Street: _____ City: _____ State: _____ Zip: _____
Date last seen for diabetes: ___/___/___
Type of Diabetes: ☐ Type I ☐ Type II
Any Complications: ☐ No complications
Yes: ☐ Neuropathy ☐ Retinopathy ☐ Kidney ☐ Skin ☐ Other
If Other, Please explain: _____

Please circle one: ☐ Working ☐ Retired
Employer: _____ Phone #: _____
Street: _____ City: _____ State: _____ Zip: _____

What is the reason for your visit today? _____

_____

When did your symptoms start? _____

On a scale of 1 – 10 (1 being no pain, 10 being the worst) what is your pain level today? _____

Quality of pain? □ Burning □ Sharp □ Ache □ Shooting □ Throbbing □ Tingling □ Other _____

What treatments have you tried? _____

Has it helped? □ Yes □ No

Is this a result of a □ Work injury □Auto accident □ Sports injury Date of Injury? ___/___/___

If work or auto, Please ask for our WC/NF Information sheet

Past medical History: _____

Past Surgical History: _____

Allergies: _____

Family Medical History: (Illnesses of immediate family) _____

_____

Social History: □ Married □ Single □ Divorced □ Widowed □ Other

Are you, or were you ever, in the military? _____

Hobbies: _____

Alcohol use: □ Yes □ No If yes, how often? _____

Tobacco use: □ Yes □ No If yes, how often? _____

Recreational Drug use: □ Yes □ No If yes, what drug and how often? _____

Current Medications: Please include dosage. □ No Medications

_____

_____

Please use the back of this form if more room is needed

Review of Systems - Please check all that apply.

GENERAL
_weight change
_ fever or chills
_ AIDS/HIV
_ dizziness/fainting
_ diabetes
_ cancer

EYE, EAR, NOSE, THROAT
_ visual changes
_ hearing changes
_ tinnitus
_ sore throat

MUSCULOSKELETAL
_ backache
_ neck pain
_ joint pain
_ joint swelling
_ fractures
_ arthritis

GASTROINTESTINAL
_ difficulty swallowing
_ stomach pain
_ Crohn's disease/IBS
_ reflux
_ ulcer

GENITOURINARY
_ urinary infection
_ incontinence
_ urinary frequency
_ venereal disease

CARDIOVASCULAR
_ high blood pressure
_ heart disease
_ stroke
_ varicose veins
_ bleeding disorder

PSYCHOLOGICAL
_ depression
_ Bipolar
_ ADD/ADHD

RESPIRATORY
_ COPD
_ tuberculosis
_ asthma
_ emphysema
_ shortness of breath

NEUROLOGIC
_ seizures
_ numbness
_ headaches

SKIN
_ bleeding gums
_ rash
_ itching/burning
_ psoriasis
_ dry patches
_ ulcerations
_ lumps/masses

Other illness: _____

__ All systems reviewed – negative

_____ Date ___/___/___ _____

Patient Signature Physician/PA Signature