Stony Brook
Orthopaedic Associates

Stony Brook Orthopaedic Associates
Follow-Up Patient Information

Name: _____ Date: _____

**Note this page will become part of your medical record **

Home Phone: _____

Cell Phone: _____

Work Phone: _____

What is your primary reason for today's visit? _____

_____

How and when did injury occur? _____

Do you have pain related to this injury? _____

When at rest, rate the pain: 0---1---2---3---4---5---6---7---8---9---10

When active, rate the pain: 0---1---2---3---4---5---6---7---8---9---10

As of today: Are you presently working? YES __ NO __ Part Time ___ Full Time ___

Date(s) Out of Work: From_____ To: _____

Are you driving? YES ___ NO ___ Are you attending school? YES___ NO ___

Are you participating in gym/sports? YES___ NO ___ N/A ___

What's New?

Since your last visit have you been to the hospital emergency room or another doctor for this problem?
Yes ___ No ___ If Yes: _____

_____

Have you had new imaging studies (X-ray/ MRI) for this problem since your last visit? Yes ___ No ___

If Yes, please list type of study(ies) , location and date: _____

_____

Are you enrolled in physical therapy and attending at least one per week? Yes ___ No ___

Other problems/injuries/complaints?_____

Are there any changes in the medication you take? Yes ___ No ___ _____

_____

Review of Systems

Do you have any problems with, or have you noticed any changes in your:

Weight/Appetite _____ Eyesight _____ Ear, Nose, Mouth, Throat _____
Heart _____ Lungs _____ Skin_____
Gastrointestinal System _____ Blood Clotting _____
Neurological _____ Immune System _____
Other _____ Allergies to Medication Latex _____

Signature of Patient _____ Date _____