Stony Brook Medicine

North Fork Orthopaedic and Sports Medicine

10095 MAIN ROAD, MATTITUCK
1600 BRECKNOCK ROAD, GREENPORT
TEL: (631) 298-4579 • FAX: (631) 298-4852

74 COMMERCE DRIVE, STE. 4, RIVERHEAD
TEL: (934) 213-4301 • FAX: (631) 213-4307
NORTHFORKORTHOPAEDICS.COM

A LOCATION OF STONY BROOK ORTHOPAEDIC ASSOCIATES

Patient Name:_____ Date:_____

E-mail address: _____

What body part is involved? LEFT☐ RIGHT☐

Neck ☐	Wrist ☐	Back ☐	Ankle ☐
Shoulder ☐	Hand ☐	Pelvis ☐	Foot ☐
Arm ☐	Finger ☐	Hip ☐	Toe ☐
Elbow ☐	Rib(s) ☐	Knee ☐	Heel ☐

How long has the problem been present? _____

How did the problem start? Gradual ☐ Sudden ☐

How did you pain begin?

Work Accident ☐
Home Accident ☐
Auto Accident ☐
Following Surgery or Illness ☐
Unknown ☐
Other:_____

****IF THIS IS A WORKER'S COMPENSATION CASE, PLEASE GIVE THE DAY OF INJURY. ****

Date of injury: _____

How did the injury occur:

_____

****IF THIS IS A NO FAULT CASE, PLEASE GIVE DATE OF ACCIDENT****

Date of accident: _____

Describe the circumstances around the onset of your pain:

_____

What medications have you taken or been given for this problem:_____

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What makes your symptoms better: Rest☐ Ice☐ Elevation☐ Walking☐ Other☐

Select the items that describe your pain:

Throbbing☐ Shooting☐ Aching☐ Stabbing☐ Burning☐

Are there any other symptoms:

Swelling☐ Numbness☐ Weakness☐ Tingling☐ Discoloration☐

Since the pain started has it:

Increased☐ Decreased☐ No Change☐

What treatments have been tried:

Injections☐ Physical Therapy☐ Brace☐

****THIS MUST BE ANSWERED****

Are you, at this time being treated with narcotic medications by another physician for this or any other problem or condition? Yes☐ No☐

Name of narcotic: _____

Reviewed by: _____ Date: _____

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Patient Name:_____ Date of Birth:_____

Reason for today's visit: (briefly state history of problem and when symptoms began)

_____

_____

Past Medical History: Have you ever had or are currently experiencing any of the following medical problems:

1) Arthritis/Gout	Yes _____	No _____
2) Anemia	Yes _____	No _____
3) Blood Pressure	Yes _____	No _____
4) Blood Clots	Yes _____	No _____
5) Bleeding Disorder	Yes _____	No _____
6) Cardiac History	Yes _____	No _____
7) Cancer	Yes _____	No _____
8) Diabetes	Yes _____	No _____
9) Dizziness or Fainting spells	Yes _____	No _____
10) Eye/Vision	Yes _____	No _____
11) Epilepsy/Seizure disorder	Yes _____	No _____
12) HIV	Yes _____	No _____
13) Hepatitis	Yes _____	No _____
14) Kidney/Urinary	Yes _____	No _____
15) Lupus	Yes _____	No _____
16) Lungs/Breathing	Yes _____	No _____
17) Muscle/Joints	Yes _____	No _____
18) Psychological	Yes _____	No _____
19) Polio	Yes _____	No _____
20) Stomach/Bowels	Yes _____	No _____
21) Stroke	Yes _____	No _____
22) Thyroid	Yes _____	No _____
23) Tuberculosis	Yes _____	No _____
24) Other	Yes _____	No _____

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Do you have any allergies to medication Yes _____ No _____

1) _____
2) _____
3) _____
4) _____

Are you allergic to latex? Yes _____ No _____

Do you have an egg allergy? Yes _____ No _____

Please list all medications that you are presently taking, including vitamins, OTC or herbal medicine.

1) _____ Reason for medication _____ Dosage _____
2) _____ Reason for medication _____ Dosage _____
3) _____ Reason for medication _____ Dosage _____
4) _____ Reason for medication _____ Dosage _____

Are you on any anticoagulants (blood thinner)? Yes _____ No _____

PAST MEDICAL HISTORY

Surgeries/Hospitalizations Year Complications

1) _____
2) _____
3) _____
4) _____

Do you have a pacemaker? Yes _____ No _____

Have you ever had general anesthesia? Yes _____ No _____

Have you ever had ANY problem with anesthesia, general or local? Yes _____ No _____

If you answered YES to either of the above questions, please explain:

_____

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FAMILY HISTORY – Please check if alive or deceased

Member	Alive	Deceased	Age	Health Status	Cause of Death
Mother					
Father					
Sister/Brother					
Sister/Brother					
Sister/Brother					

Do any of the following medical problems run in your family, including Grandparents from either side?

Heart Disease Yes _____ No _____
Cardiac Yes _____ No _____
Diabetes Yes _____ No _____
Respiratory Yes _____ No _____

SOCIAL HISTORY

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Committed/Engaged ☐
Student ☐ Retired ☐ Employed ☐
OCCUPATION: _____
Do you live alone? Yes _____ No _____
Do you exercise? Yes _____ No _____
Do you have a history of substance abuse? Yes _____ No _____ What type? _____
Do you currently smoke? Yes _____ No _____ How many years? _____ How much? _____
Quit smoking? This year ☐ Over 1 year ago ☐ Over 5 years ago ☐ Over 10 years ago ☐
Do you drink alcohol? Yes ☐ No ☐ Daily ☐ 1-2x/week ☐ 1-2x/month ☐ Rarely ☐