



**Stony Brook
Orthopaedic Associates**

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Stony Brook University Orthopaedics
Patient Follow-Up Information Form

NAME: _____ DOB: _____ TODAY'S DATE: _____

Last First M.I

Work/Sports Status: Full Time / Part Time / Injured / Disabled / Student / Retired / Playing Sports

Current School: _____ Sports/Occupation: _____

Include School & Grade Level

Include positions played

Referring Physician: _____

Name

Address

Phone#

Do you want this consult sent to your referring physician? Yes / No (If so please include Fax #) _____

CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS:

Is this a new injury that you have not been seen for before? Yes / No

Body part injured: () Left () Right _____

Date of injury / accident / onset: _____ Cause: Sports / Work / MVA / Other

How did the injury occur? _____

How does it effect / Bother you? _____

Pain at rest: (No Pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Worst pain imaginable)

Pain at activity: (No Pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Worst pain imaginable)

Does anything help decrease your pain? _____

Is this problem? Improving / Same / Worsening / Other _____

Are you in physical therapy? Yes / No, If yes where? _____

If you were / are unable to work / Play list the dates of the disability: _____ to _____

MEDICAL HISTORY:

List any changes to your medical history since your last visit: _____

List any medications since your last visit: _____

REVIEW OF SYSTEMS: (Check all that apply)

GENERAL

- () weight change
- () Fever or Chills
- () Aids / HIV
- () Night Sweats
- () Bleeding
- () Lumps or Masses
- () Dizziness or Fainting
- () Diabetes Mellitus
- () Thyroid Problems
- () Cancer

GASTROINTESTINAL

- () Difficulty Swallowing
- () Jaundice
- () Hepatitis
- () Reflux
- () Ulcer

GENITOURINARY

- () Urinary Infection
- () Incontinence
- () Urinary Frequency
- () Venereal Disease
- () Menopause

CARDIOVASCULAR

- () Chest Pain
- () Heart Disease
- () High Blood Pressure
- () Mitral Valve Prolapse
- () Thrombohebitis

NEUROLOGIC

- () Seizures
- () Numbness
- () Weakness

PROVIDER NOTES

EAR-EYE-NOSE-THROAT

- () Visual Change
- () Hearing Change
- () Tinnitus
- () Bleeding Gums

RESPIRATORY

- () Cough/Sputum
- () Tuberculosis
- () Shortness of Breath

PSYCHOLOGICAL

- () Depression
- () Bipolar
- () ADD/ADHA
- () Other

MUSCULOSKELETAL

- () Backache
- () Joint Pain
- () Joint Swelling

SKIN

- () Itching or Rash

OTHER ILLNESS:

- () All Systems Reviewed & Negative

PATIENT/GUARDIAN SIGNATURE

DATE

** PHYSICIAN'S SIGNATURE **

DATE