Stony Brook Orthopaedic Associates

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Stony Brook University Orthopaedics
New Patient Information

NAME: _____ TODAY'S DATE: _____

SEX: _____ DATE OF BIRTH: _____ SS #: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMAIL: _____ EMPLOYERS NAME/ADDRESS: _____

ARE YOU PRESENTLY WORKING? Yes / No _____

IF NO, WHEN DID YOU STOP WORKING: _____ EMPLOYERS PHONE #: _____

Referring Physician: _____

Name Address Phone#

Do you want this consult sent to your referring physician? Yes / No

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 affect/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? _____

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

MEDICAL HISTORY:

Medical Problems? _____Drug Allergies? _____

Current Medication _____

Previous Hospitalizations & Surgical Procedures: _____

FAMILY MEDICAL HISTORY: (Illness affecting patient's immediate family) _____

SOCIAL HISTORY: Married / Single / Divorced / Widowed / Other_____ **ALCOHOL USE:** Occasional / Daily / Heavy/ None

TOBACCO USE: Yes / No Type: _____ Packs Per Day: _____ Years Smoked: _____ Recreational Drug: Yes / No Type _____

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

EAR-EYE-NOSE-THROAT
( ) Visual Change
( ) Hearing Change
( ) Tinnitus
( ) Bleeding Gums

MUSCULOSKELETAL
( ) Backache
( ) Joint Pain
( ) Joint Swelling

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

CARDIOVASCULAR
( ) Chest Pain
( ) Heart Disease
( ) High Blood Pressure
( ) Mitral Valve Prolapse
( ) Thrombophlebitis

RESPIRATORY
( ) Cough/Sputum
( ) Tuberculosis
( ) Shortness of Breath
( ) Asthma
( ) Emphysema

OTHER ILLNESS: _____
( ) All Systems Reviewed & Negative

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

NEUROLOGIC
( ) Seizures
( ) Numbness
( ) Weakness

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

SKIN
( ) Itching or Rash

_____ _____ _____ _____

PATIENT/GUARDIAN SIGNATURE **DATE** **** PHYSICIAN'S SIGNATURE **** **DATE**