STONY BROOK ORTHOPAEDIC ASSOCIATES Date: _____

Established Patient Visit- Podiatry ☐ Dr. Jason Behar ☐ Dr. Lisa Riccio

Name: _____ Date of birth: ___/___/___
Contact information, if changed; _____
Has your primary insurance changed? ☐ No ☐ Yes
*If yes, please let our front desk know and have them make a copy of your new insurance card.
Diabetes-Treating Physician: _____ Phone # _____
*Date last seen for diabetes: ___/___/___
Type of Diabetes: ☐ Type I ☐ Type II
Any Complications: ☐ No ☐ Yes If yes, please let us know what type below.
☐ Neuropathy ☐ Retinopathy ☐ Kidney ☐ Skin ☐ Other: _____

What is the reason for your visit today? _____
Is this a new problem? ☐ Yes ☐ No If yes, please explain _____
_____
On a scale of 1-10 (1 being no pain and 10 being the worst) what is your pain level today? _____
Does anything make your problem better? _____
Does anything make it worse? _____
Quality of pain: ☐ Burning ☐ Sharp ☐ Ache ☐ Shooting ☐ Throbbing ☐ Tingling ☐ Other _____
Are you in physical therapy? ☐ No ☐ Yes If yes, where do you go? _____

Any changes to your medical history since your last visit? _____
_____
Any changes in your medication since your last visit? _____
_____
Any changes to Review of systems?

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

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

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

GASTROINTESTINAL
_ difficulty swallowing
_ stomach pain
_ reflux

GENITOURINARY
_ urinary infection
_ urinary frequency
_ headaches

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

PSYCHOLOGICAL
_ depression
_ ADD/ADHD

RESPIRATORY
_ COPD
_ asthma
_ shortness of breath

NEUROLOGIC
_ seizures
_ numbness

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

__ **All systems reviewed – negative**

_____ Date ___/___/___ _____
Patient signature Physician signature

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