STONY BROOK ORTHOPAEDIC ASSOCIATES DIVISION OF SPORTS MEDICINE

Stony Brook Medicine

Stony Brook University Orthopaedics

Patient Follow-Up Information Form

☐ DR. PENNA ☐ DR. CRUICKSHANK ☐ DR. CHERNEY ☐ DR. PATTERSON ☐ DR. HOPKINS

NAME:_____ DOB:_____ TODAY'S DATE:_____
LAST FIRST M.I.

CONTACT INFORMATION: (Unchanged) Changes since last visit:_____

SPORTS STATUS: (Not a sports issue) (Returned to full-done with PTx) (Returned still in PTx) (Limited) (Out)

SPORT:_____ POSITION:_____

WORK STATUS: (Not Applicable) (Working without restriction) (Light Duty) (Not working presently)

PROFESSION:_____

If you returned to work since last visit- Date of Return:_____

CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS:

INJURY(IES) OF CONCERN FOR TODAY'S VISIT:_____

WHAT IS NEW SINCE LAST VISIT:_____

_____

_____

_____

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? _____

RADIOLOGIC STUDIES SINCE LAST VISIT (MRI, XRAY, CT)?_____

MEDICAL HISTORY:

ANY CHANGES TO YOUR MEDICAL HISTORY SINCE YOUR LAST VISIT: (None)_____

_____

ANY NEW 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 PROBLEM
[ ] CANCER

EAR-EYE-NOSE-THROAT
[ ] VISUAL CHANGE
[ ] HEARING CHANGE
[ ] TINNITUS
[ ] BLEEDING GUMS

SKIN
[ ] ITCHING OR RASH

GASTROINTESTINAL
[ ] DIFFICULTY SWALLOWING
[ ] JAUNDICE
[ ] HEPATITIS
[ ] REFLUX
[ ] ULCER

CARDIOVASCULAR
[ ] CHEST PAIN
[ ] HEART DISEASE
[ ] HIGH BLOOD PRESSURE
[ ] VALVE ISSUE
[ ] BLOOD CLOT

RESPIRATORY
[ ] COUGH/SPUTUM
[ ] ASTHMA
[ ] SHORTNESS OF BREATH

GENITOURINARY
[ ] URINARY INFECTIONS
[ ] INCONTINENCE
[ ] URINARY FREQUENCY
[ ] MENOPAUSE

NEUROLOGIC
[ ] SEIZURES
[ ] NUMBNESS
[ ] WEAKNESS

PSYCHOLOGICAL
[ ] DEPRESSION
[ ] BIPOLAR
[ ] ADD/ADHD
[ ] OTHER

OTHER :_____
[ ] ALL SYSTEMS REVIEWED & NEGATIVE

PROVIDER NOTES SECTION:

_____ _____ _____ _____

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

(I HAVE REVIEWED AND DISCUSSED THE ABOVE WITH THE PATIENT.)