Stony Brook Medicine
University Physicians

Stony Brook Orthopaedic Associates

Dr. Samantha Muhlrad **New Patient Intake Form**

TODAY'S DATE: _____

PATIENT NAME: _____ DOB: _____Gender_____

HEIGHT_____ WEIGHT_____ DOMINANT HAND: RIGHT_____ LEFT_____

PHONE (HOME) _____(WORK)_____ (CELL) _____

ADDRESS_____

PHARMACY NAME AND NUMBER _____

PRIMARY CARE / REFFERING PHYSICIAN:

_____

NAME ADDRESS PHONE

REASON FOR TODAY'S VISIT: _____

DATE OF INJURY/ONSET: _____

IS THIS A WORK OR MOTOR VEHICLE RELATED INJURY? YES____ NO ____

ARE YOU CURRENTLY WORKING? YES____ NO ____

OCCUPATION _____

PAIN SCALE (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN IMAGINABLE) ***PLEASE CIRCLE***

WHAT TREATMENTS HAVE YOU TRIED?_____

REVIEW OF SYSTEMS

☐ECZEMA, SKIN RASHES ☐ DEPRESSION, ANXIETY ☐ URINARY FREQUENCY

☐ WEIGHT CHANGES ☐ PALPITATIONS, CHEST PAIN ☐ BLEEDING DISORDER

☐ HEADACHES ☐ NAUSEA/VOMITING ☐ DIFFICULTY BREATHING, SOB ☐ DIABETES

☐ VISION CHANGES ☐ THYROID DISORDERS ☐ NUMBNESS, TINGLING ☐ FEVER, CHILLS

PAST MEDICAL HISTORY / REVIEW OF SYSTEMS

ANY MAJOR ILLNESSES: NO____ YES (PLEASE LIST)_____

PREVIOUS OPERATIONS_____

CURRENT MEDICATIONS_____

MEDICATION ALLERGIES_____

FAMILY HISTORY:

REACTION TO ANESTHESIA NO_____ YES_____

INFLAMMATORY ARTHRITIS(EXP. LUPUS, RA, GOUT)_____

BLEEDING DISORDER NO_____ YES_____

TOBACCO YES____ NO ____ FREQUENCY_____ ALCOHOL YES____ NO ____ FREQUENCY_____

ILLICIT DRUGS YES____ NO ____ FREQUENCY_____

PATIENT SIGNATURE_____

PARENT/ GUARDIAN SIGNATURE_____