Stony Brook Medicine
University Physicians

Stony Brook Orthopaedic Associates

**Dr. Samantha Muhlrad** **Revisit Sheet**

**TODAY'S DATE: _____**

PATIENT NAME: _____ DOB: _____

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

CHIEF COMPLAINT: _____

DOMINANT HAND: RIGHT_____ LEFT_____

IS THIS A NEW INJURY THAT YOU HAVE NOT BEEN SEEN FOR BEFORE YES____ NO ____

DATE OF INJURY/ONSET: _____

REASON FOR TODAY'S VISIT: _____

WAS 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***

## HISTORY OF PRESENT ILLNESS *PLEASE CIRCLE WHERE NEEDED*

ARE YOUR SYMPTOMS CURRENTLY: GETTING BETTER GETTING WORSE UNCHANGED

SINCE YOUR LAST VISIT HAVE YOU HAD ANY IMAGING DONE: MRI CT EMG YES____ NO ____

PLEASE LIST_____

ARE YOU CURRENTLY IN HAND THERAPY? YES____ NO ____

ARE YOU PARTICIPATING IN SPORTS? YES____ NO ____

## 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

## MEDICAL HISTORY

LIST ANY CHANGES TO YOUR MEDICAL HISTORY SINCE YOUR LAST VISIT

_____

LIST ANY NEW MEDICATIONS SINCE YOUR LAST VISIT

_____

## SOCIAL HISTORY:

TOBACCO YES____ NO ____ ALCOHOL YES____ NO ____ ILLICIT DRUGS YES____ NO ____

IF YOU ANSWERED YES TO ANY OF THESE QUESTIONS PLEASE LIST THE FREQUENCY THAT YOU USE THEM._____

PATIENT SIGNATURE_____

PARENT/ GUARDIAN SIGNATURE_____