Stony Brook Medicine

# FOLLOW-UP PATIENT HISTORY

**TODAY'S DATE** _____

**NAME** _____ **NICKNAME**_____ **AGE**_____

**DATE OF BIRTH** _____ **HEIGHT** _____ft _____in **WEIGHT** _____lbs **BMI** _____

**IS THIS A NEW INJURY (IF YES, HOW)?** ☐ Yes ☐ No _____

**ARE YOU PRESENTLY WORKING?** ☐ Yes ☐ No **DATE(S) OUT OF WORK** _____

**WHERE IS THE PAIN?** _____

**PAIN LEVEL (1-10)?** _____ **HOW MUCH BETTER SINCE LAST VISIT?** _____%

Pain at night? ☐ Y ☐ N Difficulty Sleeping? ☐ Y ☐ N Back Pain? ☐ Y ☐ N

**WHAT MAKES IT BETTER?** _____

**WHAT MAKES IT WORSE?** _____

**WHAT MEDICATIONS ARE YOU TAKING FOR PAIN (LIST ALL)?** _____

_____

**ANY NEW SYMPTOMS SINCE PRIOR VISIT?** _____

**ANY NEW TESTS, EMERGENCY ROOM VISIT(S), OR HOSPITALIZATIONS SINCE LAST VISIT?** _____

_____

**ARE YOU TAKING ANY BLOOD THINNERS?** ☐ **Y** ☐ **N**

**HAVE YOU PARTICIPATED IN PHYSICAL THERAPY?**

☐ **Y** ☐ **N** **IF YES, LAST SESSION** _____

**ARE YOU USING A WALKING AIDE (PLEASE CIRCLE)**

**(CRUTCH/CANE/WALKER/WHEELCHAIR)?** ☐ **Y** ☐ **N**

**ANY CHANGES IN MEDICAL HISTORY SINCE LAST VISIT?**

☐ **Y** ☐ **N** _____

_____

**REVIEW OF SYMPTOMS**

Have you experienced any of these since your prior visit?

| | |
|---|---|
| Weight Loss | Weight Gain |
| Fevers | Vision Changes |
| Shortness of Breath | Cough |
| Wheezing | Chest Pain |
| Irregular Heart Rate | Leg Swelling |
| Abdominal Pain | Rectal Bleeding |
| Painful Urination | Difficulty Urinating |
| Urinary Tract Infections | Severe Back Pain |
| Leg or Foot Numbness | Leg or Foot Tingling |
| Easy Bleeding | Skin or Other Infections |

**PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR FIRST APPOINTMENT**

**STONY BROOK MEDICINE**
14 TECHNOLOGY DRIVE SUITE 11
EAST SETAUKET, NY 11733
(631) 444-4233
Update Nov 2019