Stony Brook Medicine

NEW PATIENT HISTORY

TODAY'S DATE _____

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

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

WHO REFERRED YOU HERE (NAME/ADDRESS)? _____

INTERNIST/PCP (NAME/ADDRESS) _____

CARDIOLOGIST_____**OTHER SPECIALIST(S)** _____

REASON FOR YOUR VISIT (HIP/KNEE) _____**LEFT / RIGHT / BOTH** for _____ MONTHS_____ YRS

WHERE IS THE PAIN? (FRONT/BACK/INNER/OUTER/ALL OVER) _____

WHAT MAKES IT BETTER? _____

WHAT MAKES IT WORSE? _____

Have you tried any of the following? ☐ Bracing ☐ Cane ☐ Weight Loss _____lbs ☐ Therapy How Long? _____

Injections: ☐ Steroid (Last): _____ How Many? ___ ☐ Visco (Synvisc, Euflexxa, etc) Last: _____ How Many? _____

☐Anti-Inflammatory Medications (past & present – which? Aleve, Advil, Ibuprofen, Celebrex, Mobic, Naprosyn, etc.)

_____

Have you had surgery on this body part? (Scope or Other/When _____

Have you had any other treatment not listed? _____

Have you seen other providers for this condition? (Who/When) _____

Pain at night? ☐ Y ☐ N Difficulty Sleeping? ☐ Y ☐ N Back Pain? ☐ Y ☐ N Pain Level (1-10) _____

PAIN: Mild Moderate Severe Totally Disabling **LIMP:** Mild Moderate Severe Unable to Walk

NEED ASSISTANCE? None Cane at Times Cane Full Time Walker Wheelchair

HOW FAR CAN YOU WALK? Unlimited 6 Blocks 2-3 Blocks Indoor Only Unable

CAN YOU CLIMB STAIRS? Normally Normally with Rail Assistance With Difficulty Unable

CAN YOU PUT ON SOCKS AND SHOES? With Ease With Difficulty Unable

WHAT IS YOUR ACTIVITY LEVEL? Bedridden Sedentary Semi-Sedentary Light Labor Moderate/Heavy Labor

PLEASE BRING THIS COMPLETED FORM (FRONT AND BACK) WITH YOU TO YOUR FIRST APPOINTMENT

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

What are some examples of how your pain impacts your daily life? (things you can no longer do or do comfortably):

_____

_____

PAST MEDICAL HISTORY Have you ever had or been told by a doctor that you have any of the following?

Anemia	Aneurysm	Cardiac Arrhythmia	Blood Clots (DVT/PE)
Carotid Artery Disease	Congestive Heart Failure	Cardiac Disease	Lung Disease
Diabetes	GI Bleeding	GERD/Reflux	Hypothyroidism
Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease
Peptic Ulcer Disease	Peripheral Vascular Disease	Stroke/TIA	Seizures
Asthma	Migraine or Severe Headaches	Hepatitis	HIV
Cancer	Excessive Bleeding or Bruising	Emphysema or COPD	Serious Infections

Psychiatric Conditions (Depression/Anxiety/Other): _____

Other Conditions: _____

DENTAL HISTORY

Any active dental problem? ☐Y ☐N IF YES, WHAT? _____ Most recent dental appointment: _____

PAST SURGICAL TREATMENT (List surgical procedures and year performed)

_____

_____

_____

Have you had any major issues (complications) with prior surgeries? _____

SIGNIFICANT FAMILY HISTORY: _____

MEDICATIONS (List name, dosage and frequency taken. Attach list if applicable)

_____

_____

_____

ALLERGIES (To Medicines or Metals**)**

_____

_____

SOCIAL HISTORY

Single Married Widowed

Live with: Name: _____

Relationship: _____

Retired? ☐Y ☐N Occupation:_____

Tobacco? ☐Y ☐N Packs/day:_____

Alcohol? ☐Y ☐N Drinks/week: _____

Drug Use? ☐Y ☐N _____

Interests/Hobbies: _____

REVIEW OF SYMPTOMS

Have you experienced any of the following in the past year?

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