Stony Brook Orthopaedic Associates

SPINE AND SCOLIOSIS CENTER

TODAY'S DATE: _____

PATIENT NAME: _____ DOB: _____Gender_____

PRIMARY LANGUAGE: ENGLISH_____ SPANISH_____ OTHER_____

CAN YOU READ ENGLISH? YES ____ NO ____ DO YOU UNDERSTAND ENGLISH? YES ____ NO ____

WHAT IS YOUR OCCUPATION? _____

TYPE OF WORK: HEAVY LABOR _____ LIGHT LABOR_____ SEDENTARY _____

ARE YOU CURRENTLY EMPLOYED? YES____ NO ____

STATUS: FULL TIME ____ PART TIME ____ DECREASED CAPACITY ____ DISABLED ____ RETIRED ____

IF NOT WORKING, WHEN DID YOU STOP? ___/___/___

DID YOU SUFFER AN INJURY? YES_____ NO_____ DATE___/___/____ IS IT WORK RELATED? YES____ NO ____

DESCRIBE: _____

DO YOU HAVE PAIN? YES ____ NO ____

IF YES, PLEASE DESCRIBE:

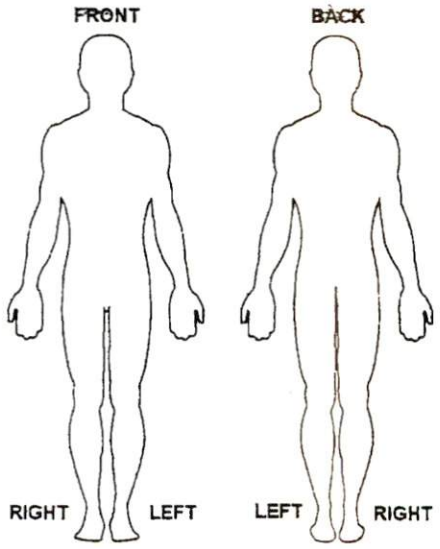
_____

_____

WHERE IS YOUR PAIN NOW?

PLEASE USE THE APPROPRIATE SYMBOLS TO DESCRIBE YOUR SYMPTOMS AND MARK THE LOCATION AS ACCURATELY AS POSSIBLE ON THE BODY DRAWING:

ACHING	^ ^ ^ ^ ^
STABBING	/ / / / / / / /
TINGLING	_____
BURNING	X X X X X
NUMBNESS	0 0 0 0 0 0



PLEASE RATE PAIN ACCORDING TO THE SCALE BELOW

0	1	2	3	4	5	6	7	8	9	10
NO PAIN		MILD		DISCOMFORT		DISTRESSING		HORRIBLE		EXCURCIATING

WHEN DID THE PAIN BEGIN? _____

HOW DID THE PAIN START? _____

WHERE IS THE PAIN LOCATED? NECK____ BACK____ ARM____ LEG____

DESCRIBE_____

_____

DOES THE PAIN AWAKEN YOU FROM SLEEP? YES ____ NO ____

IS YOUR PAIN: IMPROVING____ WORSENING____ STAYING THE SAME OVER TIME ____

WHAT AGGRAVATES YOUR PAIN?_____

WHAT HELPS YOUR PAIN? _____

PAIN IS WORSE: _____

PAIN IS LEAST: _____

DO YOU EXPERIENCE WEAKNESS IN THE EXTREMITIES? YES ____ NO____

IF YES PLEASE DESCRIBE: _____

_____

HAVE YOU HAD TREATMENT FOR YOUR CONDITION?

NONE ____ PHYSICAL THERAPY ____ CHIROPRACTOR ____ EPIDURAL STEROID ____ ACCUPUNCTURE ____

TRIGGERPOINT INJECTIONS ____ PAIN MANAGEMENT ____ SURGERY____

OTHER_____

PLEASE DETAIL ANY SIGNIFICANT PAST MEDICAL HISTORY: _____

_____

_____

_____

_____

_____

PLEASE DETAIL ANY PAST SURGICAL HISTORY:_____

_____

_____

_____

_____

_____

PLEASE LIST ANY ALLERGIES: _____

PLEASE LIST ALL CURRENT MEDICATIONS: (**PLEASE CONTINUE ON BACK OF THIS PAPER IF YOU NEED MORE ROOM**)

DRUG	DOSE	FREQUENCY

DO YOU HAVE ANY SIGNIFICANT FAMILY MEDICAL HISTORY?

PLEASE DESCRIBE: _____

_____

_____

_____

DO YOU HAVE BOWEL / BLADDER INCONTINENCE? YES____ NO ____

IF YES PLEASE DESCRIBE: _____

_____

DO YOU SMOKE? YES ____ NO ____ CIGARETTES _____ CIGARS _____ PIPE _____ OTHER _____

DO YOU DRINK? YES ____ NO _____ IF YES HOW OFTEN _____ HOW MANY _____

REVIEW OF SYSTEMS

(PLEASE CHECK ALL THAT APPLY)

- ☐ ULCER
- ☐ HIATAL HERNIA
- ☐ INDIGESTION
- ☐ DIABETES
- ☐ HEPATITIS (YELLOW SKIN)

- ☐ FRACTURES NECK/SKULL
- ☐ ARTHRITIS
- ☐ BACK PROBLEMS
- ☐ CORTISONE THERAPY IN THE PAST YEAR
- ☐ SWOLLEN/SORE LEGS

- ☐ STROKE
- ☐ HEART PROBLEMS
- ☐ LOW BLOOD PRESSURE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIATAL HERNIA
- ☐ CHEST PAIN
- ☐ MITRAL VALVE PROLAPSE

- ☐ LIVER PROBLEMS
- ☐ KIDNEY PROBLEMS
- ☐ THYROID DISEASE

- ☐ POLIO/ MENINGITIS
- ☐ JAW PROBLEMS/TMJ
- ☐ GLAUCOMA
- ☐ IMPAIRED VISION

- ☐ IMPAIRED HEARING
- ☐ BLACKOUTS/ DIZZINESS
- ☐ READING
- ☐ SPEAKING PROBLEMS

- ☐ ANEMIA
- ☐ SICKEL CELL ANEMIA
- ☐ BRUISE OR BLEED EASILY
- ☐ BLOOD CLOTS
- ☐ SICKEL CELL ANEMIA
- ☐ THYROID DISEASE

- ☐ SKIN RASHES
- ☐ MOTION SICKNESS
- ☐ CANCER
- ☐ CHEMOTHERAPY
- ☐ RADIATION

- ☐ EPILEPSY/SEIZURES
- ☐ HEADACHES
- ☐ LUNG PROBLEMS (ASTHMA/SOB/INHALER)
- ☐ EMOTIONAL PROBLEMS
- ☐ SLEEPA APNEA

CULTURAL BELIEFS: _____

_____

_____

_____

_____

_____

COMMENTS: _____

_____

_____

_____

_____

_____

_____ DATE_____

PATIENT / GUARDIAN SIGNATURE

Stony Brook Medicine

Department of Radiology

Hospital Radiology Services

Dear Patient,

Thank you for choosing Stony Brook Medicine for your care and treatment. Please be advised that the Radiological Services provided here during this office visit are a Stony Brook University Hospital Service.

If you are having x-rays taken as part of today's visit, your insurance carrier will be billed separately for the professional and technical portions of the x-ray as a Hospital Service. The technical portion of the bill covers the costs of equipment, supplies, the radiology technician and other hospital personnel. The professional portion covers the personal professional services of the radiologist (physician) who will interpret the radiological test.

In addition to your usual co-payment for your doctor office visit, you may incur another co-payment for the hospital based x-ray services or based on your insurance carrier, the fees could be applied towards your Hospital Deductible.

Please call your insurance carrier to determine your benefits related to outpatient hospital diagnostic services.

Please acknowledge that you have read the above statement by signing below:

_____ _____

SIGNATURE NAME OF PATIENT

_____

PRINT NAME

_____

DATE OF SERVICE

HSC-L4-092, STONY BROOK, NEW YORK 11794-8420 TEL: 631-444-2420 FAX: 631-444-3443

Stony Brook Medicine

NARCOTIC MEDICATION POLICY

Please note that Stony Brook Orthopedics is a consultation and treatment center. We are here to diagnose and treat orthopedic conditions. We are not a Pain Management Center. Our physicians will only dispense narcotic medication to post-operative patients, or patients with acute conditions such as fractures. These patients will then be weaned off of narcotic medications over a period of weeks. If you require narcotic medications on a regular basis, we suggest you seek the services of a pain management service or obtain them from your Primary Care Physician.

Please acknowledge that you have read the above statement by signing below.

MR#: _____ Date: _____

Print Name: _____

Signature: _____

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