STONY BROOK ORTHOPAEDIC ASSOCIATES DIVISION OF SPORTS MEDICINE

Stony Brook Medicine

Stony Brook University Orthopaedics
New Patient Information Form

☐ DR. PENNA ☐ DR. CRUICKSHANK ☐ DR. CHERNEY ☐ DR. PATTERSON

NAME:_____ _____
LAST FIRST M.I. NAME TO BE CALLED

TODAY'S DATE: _____ SEX: _____ DATE OF BIRTH: _____ SS# (last 4)_____
ADDRESS: _____
STREET # & NAME OR P.O. BOX CITY STATE ZIP

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
EMAIL: _____ PATIENT'S EMPLOYER: _____
NAME OF SPOUSE/PARTNER/GUARDIAN: _____ EMPLOYER:_____
WORK/SPORTS STATUS: Full Time / Part Time / Injured / Disabled / Student / Retired / Playing Sports
CURRENT SCHOOL: _____ SPORTS/OCCUPATION: _____
INCLUDE GRADE/LEVEL INCLUDE POSITIONS

REFERRING PHYSICIAN: _____
NAME ADDRESS PHONE # ***(Do you want a letter sent to them? YES/NO)***

PRIMARY CARE PHYSICIAN:_____
NAME ADDRESS PHONE # ***(Do you want a letter sent to them? YES/ NO)***

COACH: (if applicable) _____
NAME ADDRESS PHONE # ***(Do you want a letter sent to them? YES / NO)***

ATHLETIC TRAINER: (if applicable) _____
NAMES SCHOOL/TEAM PHONE # ***(Do you want a letter sent to them? YES / NO)***

INSURANCE: PRIMARY:_____ SECONDARY: _____
NAME OF INSURED PARTY:_____
DOES THIS VISIT INVOLVE A WORKMAN'S COMPENSATION ISSUE? YES / NO
ARE YOU INVOLVED IN, OR PLAN TO PERSUE LITIGATION DUE TO THIS INJURY? YES / NO

CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS:

BODY PART INJURED: ☐LEFT ☐RIGHT_____ HAND DOMINANCE: ☐LEFT ☐RIGHT
DATE OF INJURY/ACCIDENT/ONSET: _____ CAUSE: SPORTS/WORK/MVA/OTHER
HOW DID THE INJURY OCCUR?_____
HOW DOES IT EFFECT / BOTHER YOU?_____

PAIN AT REST: (No Pain**) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Worst Pain Imaginable)

PAIN AT ACTIVITY: (No Pain**) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Worst Pain Imaginable)

DOES ANYTHING HELP DECREASE YOUR PAIN? _____
HAVE YOU BEEN TREATED FOR THIS PROBLEM BEFORE? YES / NO DATE(S):_____
BY WHOM? _____
PRIOR SURGERY FOR THIS PROBLEM? YES / NO DATE(S):_____
PHYSICAL THERAPY FOR THIS PROBLEM? YES / NO IF YES, WHERE: _____
IF YOU WERE/ARE UNABLE TO WORK/PLAY LIST DATES OF DISABILITY:_____to_____
HAVE YOU HAD ANY PRIOR IMAGING STUDIES FOR THIS PROBLEM? YES / NO
IF YES, LIST FACILITY, TYPE & DATE:_____

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PAST MEDICAL HISTORY:

MEDICAL PROBLEMS:_____

_____

PREVIOUS HOSPITALIZATIONS & SURGICAL PROCEDURES: (Provide Dates) _____

_____

_____

FOOD/DRUG ALLERGIES: _____

CURRENT MEDICATIONS: (Include Doses and Frequency)_____

_____

_____

FAMILY MEDICAL HISTORY: (Include Medical Illness Affecting Patient's Immediate Family)

_____

_____

SOCIAL HISTORY: (Check Boxes and Fill Blanks)

☐MARRIED ☐SINGLE ☐ DIVORCED ☐ WIDOWED ☐OTHER:_____

ALCOHOL USE: ☐ OCCASIONAL ☐DAILY ☐HEAVY ☐ NONE

TOBACCO USE: ☐YES ☐ NO (TYPE:_____PACKS PER DAY:_____ YEARS USED: _____)

☐ RECREATIONAL DRUG USE: ☐YES ☐ NO (TYPE(S):_____)

REVIEW OF SYSTEMS: (Check All That Apply)

GENERAL
[ ] WEIGHT CHANGE
[ ] FEVER OR CHILLS
[ ] AIDS/HIV
[ ] NIGHT SWEATS
[ ] BLEEDING
[ ] LUMPS OR MASSES
[ ] DIZZINESS OR FAINTING
[ ] DIABETES MELLITUS
[ ] THYROID PROBLEM
[ ] CANCER

EAR-EYE-NOSE-THROAT
[ ] VISUAL CHANGE
[ ] HEARING CHANGE
[ ] TINNITUS
[ ] BLEEDING GUMS

MUSCULOSKEKETAL
[ ] BACKACHE
[ ] JOINT PAIN
[ ] JOINT SWELLING

GASTROINTESTINAL
[ ] DIFFICULTY SWALLOWING
[ ] JAUDICE
[ ] HEPATITIS
[ ] REFLUX
[ ] ULCER

CARDIOVASCULAR
[ ] CHEST PAIN
[ ] HEART DISEASE
[ ] HIGH BLOOD PRESSURE
[ ] MITRAL VALVE PROLAPSE
[ ] THROMBOHLEBITIS

RESPIRATORY
[ ] COUGH/SPUTUM
[ ] TUBERCULOSIS
[ ] SHORTNESS OF BREATH
[ ] ASTHMA
[ ] EMPHYSEMA

OTHER ILLNESS :_____
[ ] ALL SYSTEMS REVIEWED & NEGATIVE

GENITOURINARY
[ ] URINARY INFECTIONS
[ ]INCONTINENCE
[ ] URINARY FREQUENCY
[ ] VENERAL DISASE
[ ] MENOPAUSE

NEUROLOGIC
[ ] SEIZURES
[ ] NUMBNESS
[ ] WEAKNESS

PSYCHOLOGICAL
[ ] DEPRESSION
[ ] BIPOLAR
[ ] ADD/ADHD
[ ] OTHER

SKIN
[ ] ITCHING OR RASH

PROVIDER NOTES SECTION:

_____ _____ _____ _____

PATIENT/GUARDIAN SIGNATURE DATE **PHYSICIAN'S SIGNATURE** DATE

(I HAVE REVIEWED AND DISCUSSED THE ABOVE WITH THE PATIENT.)