David Wallach MD
Stony Brook University Orthopaedics
Follow-up Patient Information

Name:________________________ Date:__________

****Please note that this page will become part of your medical chart****

Home Phone: ____________ Cell: ____________ Work: ____________
Email: ______________________ (your email will not be distributed to any third parties)

Chief Complaint:
What is your Primary reason for today's visit? ______________________
____
How & When did injury occur?______________________
If pain is a major component of the primary problem:
When at rest, rate the pain- 0—1—2—3—4—5—6—7—8—9—10
When doing activity, rate the pain: 0—1—2—3—4—5—6—7—8—9—10

As of today...:
Are you presently working: Yes / No *Date(s) Out Of Work* ________ to ________
(Full Time) (Part Time) (Light Duty)
Are you driving? Yes / No
Are you attending school: Yes / No
Are you participating in gym or sports?: Yes / No / Not relevant

What's New? :
Since your last visit have you been to the hospital (ER) or another doctor for this problem?
(Yes / No) If Yes :______________________
Have you had new imaging studies (ie. Xray/MRI) done for this problem since your last visit? (Yes / No) If Yes, please list type of study(ies), location and date:____________
____
Are you currently enrolled in physical therapy and attending at least once/wk? (Yes / No)
Other problems/injuries/complaints? ______________________
____
Have there been any changes to the medication that you take? (Yes / No)____________
____

Review of Systems:
Do you have any problems with, or have you noticed any changes in your-
Weight/Appetite________ Eyesight________ Ear,Nose,Mouth,Throat________
Heart________ Lungs________ Skin________
Gastrointestinal System________ Blood Clotting________
Neurological System________ Immune System________
Other:______________________
Allergies to Medications/Latex:______________________

Signature of Patient/Guardian X______________________ Date:__________
I have reviewed this form X______________________ Date:__________
David Wallach, MD

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