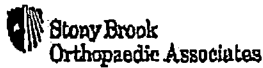

Stony Brook Orthopaedic Associates
Follow-Up Patient Information

Name: ______________________________ Date: ____________________

**Note this page will become part of your medical record **

Home Phone: ____________________

Cell Phone: ____________________

Work Phone: ____________________

What is your primary reason for today's visit? ______________________________

____

How and when did injury occur? ______________________________

Do you have pain related to this injury? ______________________________

When at rest, rate the pain: 0---1---2---3---4---5---6---7---8---9---10

When active, rate the pain: 0---1---2---3---4---5---6---7---8---9---10

As of today: Are you presently working? YES __ NO __ Part Time ___ Full Time ___

Date(s) Out of Work: From____________________ To: ____________________

Are you driving? YES ___ NO ___ Are you attending school? YES___ NO ___

Are you participating in gym/sports? YES___ NO ___ N/A ___

What's New?

Since your last visit have you been to the hospital emergency room or another doctor for this problem?
Yes ___ No ___ If Yes: ______________________________

____

Have you had new imaging studies (X-ray/ MRI) for this problem since your last visit? Yes ___ No ___

If Yes, please list type of study(ies) , location and date: ______________________________

____

Are you enrolled in physical therapy and attending at least one per week? Yes ___ No ___

Other problems/injuries/complaints?______________________________

Are there any changes in the medication 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 ____________ Immune System ____________
Other ____________ Allergies to Medication Latex ____________

Signature of Patient ____________________ Date ____________________