Stony Brook Medicine

North Fork Orthopaedic and Sports Medicine
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A LOCATION OF STONY BROOK ORTHOPAEDIC ASSOCIATES

Initial History Form

Patient Name: _____ Date: _____

E-mail address: _____

What body part is involved? LEFT or RIGHT

Neck	**Shoulder**	**Arm**	**Elbow**	**Wrist**	**Hand**	**Finger**	**Rib(s)**
Back	**Pelvis**	**Hip**	**Knee**	**Ankle**	**Foot**	**Toe**	**Heel**

How long has the problem been present? _____

How did the problem start? Gradual _____ **or** Sudden _____

How did your pain begin?
Work Accident
Home Accident
Auto Accident
Other: _____
Following surgery or illness
Unknown

**** IF THIS IS A WORKER'S COMPENSATION CASE, PLEASE GIVE DATE OF INJURY** _____ **(MM/DD/YYYY.**

How did the injury occur? _____

**** IF THIS IS A NO FAULT CASE, PLEASE GIVE DATE OF ACCIDENT** _____ **(MM/DD/YY)**

Describe the circumstances around the onset of your pain: _____

_____.

What medications have you taken or been given for this problem? _____.

What makes your symptoms better? Rest __Heat __Ice __Elevation __Walking __Other____

Select the items that describe your pain: Throbbing __Shooting__ Aching__ Stabbing__ Burning__

Are there any other symptoms? Swelling __Numbness __Weakness __Tingling__ Discoloration ___

Since the pain started has it: Increased ____ Decreased ____ No Change ____

What treatments have been tried? Injection ___ Physical Therapy ___ Brace ___

****This must be answered **** Are you, at this time being treated with narcotic medications by another physician for this or any other problem/condition? **Yes __No __**

Name of narcotic: _____

Reviewed By: _____ **Date:** _____

Patient Name: _____ **Date of Birth:** _____

Reason for today's visit: (briefly state history of problem and when symptoms began)

_____

_____.

Past Medical History: Have you ever had or are currently experiencing any of the following medical problems:

1) Arthritis/Gout Yes___ No___ Explain _____
2) Anemia Yes___ No___ Explain _____
3) Blood pressure Yes___ No___ Explain _____
4) Blood Clots Yes___ No___ Explain _____
5) Bleeding Disorder Yes___ No___ Explain _____
6) Cardiac History Yes___ No___ Explain _____
7) Cancer Yes___ No___ Explain _____
8) Diabetes Yes___ No___ Explain _____
9) Dizziness or Fainting spells Yes___ No___ Explain _____
10) Eye/Vision Yes___ No___ Explain _____
11) Epilepsy/Seizure disorder Yes___ No___ Explain _____
12) HIV Yes___ No___ Explain _____
13) Hepatitis Yes___ No___ Explain _____
14) Kidney/urinary Yes___ No___ Explain _____
15) Lupus Yes___ No___ Explain _____
16) Lungs/Breathing Yes___ No___ Explain _____
17) Muscle/Joints Yes___ No___ Explain _____
18) Psychological Yes___ No___ Explain _____
19) Polio Yes___ No___ Explain _____
20) Stomach/Bowels Yes___ No___ Explain _____
21) Stroke Yes___ No___ Explain _____
22) Thyroid Yes___ No___ Explain _____
23) Tuberculosis Yes___ No___ Explain _____
24) Other Yes ___ No __ Explain _____

****DO YOU HAVE ANY MEDICATION ALLERGIES**** **YES** _____ **NO** _____

1) _____ **2)** _____ **3)** _____ **4)** _____

ARE YOU ALLERGIC TO LATEX? **YES** ____ **NO** _____
DO YOU HAVE AN ALLERGY TO EGGS? **YES** ____ **NO** _____

Please list all medications that you are presently taking, including vitamins, OTC, or herbal medicine.

1) _____ **Reason for medication** _____ **Dosage** _____
2) _____ **Reason for medication** _____ **Dosage** _____
3) _____ **Reason for medication** _____ **Dosage** _____
4) _____ **Reason for medication** _____ **Dosage** _____

Are you on any anticoagulants (blood thinner)? **Yes** _____ **No** _____

PAST MEDICAL HISTORY

Surgeries/Hospitalizations **Year** **Complications**

1) _____
2) _____
3) _____
4) _____

Do you have a Pacemaker? **Yes**_____ **No**_____
Have you ever had general anesthesia? **Yes**_____ **No**_____
Have you ever had ANY problem with anesthesia, general or local? **Yes**___ **No**____
If you answered **YES** to either of the above questions, please explain:

_____

FAMILY HISTORY- Please check if alive or deceased

Member	**Alive**	**Deceased**	**Age**	**Health status OR cause of death**
Mother				
Father				
Sister/Brother				
Sister/Brother				
Sister/Brother				

Do any of the following medical problems run in your family, including Grandparents from either side?

Heart Disease **Yes**_____ **No**_____
Cardiac **Yes**_____ **No**_____
Diabetes **Yes**_____ **No**_____
Respiratory **Yes**_____ **No**_____

SOCIAL HISTORY

Single ___Married ___Divorced ____Widowed ____Separated___ Committed/Engaged___
Student____ Retired ____ Employed _____
OCCUPATION:_____
Do you live alone? **Yes**_____ **No**_____
Do you exercise? **Yes**_____ **No**_____ **What type of exercise?** _____
Do you have a history of substance abuse? **Yes** ____ **No**____, **what type:** _____
Do you currently smoke? **Yes** __**No**__ **How many years** _____ **How much?** _____
Quit smoking? **This year**__ **Over 1 year ago**___ **Over 5 years ago** ____**Over 10 years ago**____
Do you drink alcohol? **Yes** ____**No** ___**Daily**___**1-2 x a week** ____**1-2 x a month**___ **Rarely**____