Stony Brook Medicine

Stony Brook Extended Care
A LOCATION OF STONY BROOK INTERNIST
UNIVERSITY ASSOCIATES IN OBSTETRICS & GYNECOLOGY

OPKAR CHAWLA, MD
ELIZABETH JEREMIAS, MD
JASJIT KOCHAR, MD
STONYBROOKEXTENDEDCARE.COM

23 South Howell Avenue, Suites A, B & C, Centereach, NY 11720 Phone: 631-542-0550 Fax: 631-650-7473

New Patient Medical History

Name: _____ Date of Birth: ___/___/ 19___ Age: ____ Sex: ____
How did you hear about our practice?

Please briefly state in the box below the reason for your visit

Past Medical History			
Condition / Disease	***Year Began***	***Condition / Disease***	***Year Began***
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hyper/Hypothyroidism			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Conditions			

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures			
Operation / Hospitalization / Injury	***Month / Yr***	***Operation / Hospitalization / Injury***	***Month / Yr***

Other Physicians and Specialists *List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc.)*

Medication/Food Allergies or Intolerances *List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)*			
Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

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Family Health History				
Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				
Children:				

Health Maintenance				
Test Performed	***Date***			
Lipid (Cholesterol)		Abnormal?	Yes ☐	No ☐
Colonoscopy		Abnormal?	Yes ☐	No ☐
Mammography		Abnormal?	Yes ☐	No ☐
Pap Smear		Abnormal?	Yes ☐	No ☐
Bone Density		Abnormal?	Yes ☐	No ☐
Dental Exam				
Eye Exam				

Vaccinations	
	Date
Tetanus (Tdap)	
Influenza	
Pneumovax (Pneumonia)	
Zostavax (Shingles)	

Current Medications			
Medication	Dosage	Medication	Dosage

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Social, Educational and Work History	
Marital Status:	
Work Status (circle one): Employed/ Unemployed / Retired / Disabled	Hours worked per week:
Do you drink alcohol?	Number of drinks per week?
Are you a smoker?	If yes, how many packs per day?
Are you a former smoker?	If yes, what year did you quit?
Do you exercise?	Duration and Frequency?

Review of Systems

*Please mark any **persistent** symptoms you have had in the **past few months.** Read through every section and mark "no problems" if none of the symptoms apply to you.*

General
__ Unexplained weight loss/gain
__ Unexplained fatigue/weakness
__ Fever/chills
__ **No problems**

Skin
__ New or change in mole
__ Rash/itching
__ **No problems**

Breast
__ Breast pain/lump/nipple discharge
__ **No problems**

Ears/Nose/Throat
__ Nosebleeds
__ Trouble swallowing
__ Frequent sore throat, hoarseness
__ Hearing loss/ringing in ears
__ **No problems**

Eyes
__ Change in vision
__ Eye pain
__ Eye redness
__ **No problems**

Cardiovascular
__ Chest pain/discomfort
__ Palpitations (fast or irregular heartbeat)
__ **No problems**

Respiratory
__ Cough/Wheeze
__ Loud snoring/altered breathing during sleep
__ Short of breath with exertion
__ **No problems**

Gastrointestinal
__ Heartburn/reflux/indigestion
__ Blood or change in bowel movement
__ Constipation
__ **No problems**

Genitourinary
__ Leaking urine
__ Blood in urine
__ Nighttime urination or increased frequency
__ Discharge from penis or vagina
__ Concern with sexual function
__ **No problems**

Musculoskeletal
__ Neck pain
__ Back pain
__ Muscle/joint pain
__ **No problems**

Endocrine
__ Heat or cold sensitivity
__ **No problems**

Hematologic/Lymphatic
__ Swollen glands
__ Easy bruising
__ **No problems**

Neurological
__ Headache
__ Memory Loss
__ Fainting
__ Dizziness
__ Numbness/tingling
__ Unsteady gait
__ Frequent falls
__ **No problems**

Allergic/Immune
__ Hay fever/allergies
__ Frequent infections
__ **No problems**

Psychiatric
__Anxiety/stress/irritability
__ Sleep problems
__ Lack of concentration
__ **No problems**

Women only
__ Pre-menstrual symptoms (bloating, cramps, irritability)
__ Problem with menstrual periods
__ Hot flashes/night sweats
__ **No problems**

Please list any other concerns here: _____

_____

_____

_____

_____