

STONY BROOK SURGICAL ASSOCIATES

PATIENT ASSESSMENT FORM (new patients only)

Please complete all sections

Patient Information		HGT	WGT	SS#
Name (Last, First, MI)		DOB	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Home Phone	Work Phone		Cell Phone	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Occupation		
Religion		Race/Ethnicity		
Preferred Language		Interpreter? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Name of Pharmacy		Phone		
Reason for Visit: _____				
Do you have any pain related to your presenting complaint/condition? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, Pain Tool must be completed)				
Social Habits <input type="checkbox"/> N/A				
Alcohol <input type="checkbox"/> No <input type="checkbox"/> Yes (frequency) _____		Cocaine <input type="checkbox"/> No <input type="checkbox"/> Yes	Narcotics/Drug Use <input type="checkbox"/> No <input type="checkbox"/> Yes	
Smokes Tobacco <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, # of Yrs _____ # of Packs/Day _____		When Stopped _____	
Is your child or others exposed to second hand smoke inside or outside of home? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Current Health Care Proxy <input type="checkbox"/> No <input type="checkbox"/> Yes		Living Will <input type="checkbox"/> No <input type="checkbox"/> Yes		
Cultural & Religious Beliefs that May Affect Care <input type="checkbox"/> No <input type="checkbox"/> Yes _____				
Do you prefer to learn by <input type="checkbox"/> Seeing (TV, Video, Written) <input type="checkbox"/> Hearing (Audio) <input type="checkbox"/> Doing (Hands On)				
Do you have any barriers to learning (please check) <input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Vision <input type="checkbox"/> Financial <input type="checkbox"/> Hearing <input type="checkbox"/> Cognitive				
Can you read and understand English? <input type="checkbox"/> No <input type="checkbox"/> Yes		What is your first language? _____		
Hospitalization/Surgery/Major Illness <input type="checkbox"/> N/A				
<u>PROBLEM</u>	<u>YEAR</u>	<u>WHERE TREATED</u>	<u>DAYS IN HOSPITAL</u>	
Blood Transfusion <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____ Complications: _____				
Gynecologic/Obstetric History (ENT patients do not need to complete) <input type="checkbox"/> N/A				
Any Pregnancies? <input type="checkbox"/> No <input type="checkbox"/> Yes (how many) _____		How many children have you given birth to? _____		
How many abortions/miscarriages? _____		Going through menopause? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Date of last period _____		Monthly breast exams? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Lumps on breasts? <input type="checkbox"/> No <input type="checkbox"/> Yes		Date of last mammogram: _____		
Medications (Please list all medications you are currently taking, including vitamins and supplements)				
1. _____		6. _____		
2. _____		7. _____		
3. _____		8. _____		
4. _____		9. _____		
5. _____		10. _____		
Previous Bleeding Problems? <input type="checkbox"/> No <input type="checkbox"/> Yes		Herbal medications? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Allergies to Medication? <input type="checkbox"/> No <input type="checkbox"/> Yes (type of reaction) _____				
Food Allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes (please specify) _____				
Nutritional Data				
Are you following a special diet? <input type="checkbox"/> No <input type="checkbox"/> Yes _____				
Unintentional Weight <input type="checkbox"/> Over/Under 5 lbs in 1 month <input type="checkbox"/> Over/Under 10 lbs in 3-6 months				
Appetite <input type="checkbox"/> Good (eat 3+ meals/day) <input type="checkbox"/> Fair (1-2 meals/day) <input type="checkbox"/> Poor (less than 1 meal/day)				

NAME _____

MRN# _____

Personal/Family History (Check all that apply for patient and/or family member)

IF YES	PATIENT/HOW OFTEN	FAMILY MEMBER/HOW OFTEN
Allergies	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Amputation	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Anesthesia Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Angina	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Anxiety or Depression	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Asthma	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Bleeding/Bruising Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Bowel Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Cancer	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Chest Pain/Heart Disease	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Diabetes Mellitis	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Dizziness	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Ear Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Eye Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Headaches	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Heartburn	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Hepatitis	<input type="checkbox"/> _____	<input type="checkbox"/> _____
High Blood Pressure	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Hyperthermia/Hyperpyrexia (malignant)	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Kidney Disease	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Known Genetic Disorder	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Mental Retardation/Illness	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Moles that are changing	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Nasal Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Pain in Joints/Limbs	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Persistent Cough/Wheezing	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Prostate Enlargement	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Rashes, Sores, Itching	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Ringling in Ears	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Seizure Disorder	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Shortness of Breath	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Skin Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Stroke	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Thyroid Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Trouble Sleeping	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Tuberculosis/Lung Disease	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Stomach/Leg Ulcers	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Urination Problems	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Weakness/Numbness	<input type="checkbox"/> _____	<input type="checkbox"/> _____
OTHER _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> CHECK IF NONE APPLY	<input type="checkbox"/> _____	<input type="checkbox"/> _____

Personal/Social History

Residence Nursing Home Private Home Live Alone Apartment Shelter Other _____

Who will assist in your care Spouse Family Friend Self Other (name and phone) _____

Do others depend on you for their care? No Yes N/A

Are you currently in a domestic violence situation? No Yes

COMPLETED BY: _____ DATE: _____

REVIEWED BY: _____ ID # _____ DATE: _____