Stony Brook
Orthopaedic Associates

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Stony Brook Medicine - Orthopaedics

Patient Follow-Up Information

NAME:____ **DOB:** ___________________ **TODAY'S DATE:** ____________________

Last First M.I

Work/Sports Status: Full Time / Part Time / Injured / Disabled / Student / Retired / Playing Sports

Current School: ____ Sports/Occupation:_______________________________________

Include School & Grade Level Include positions played

Referring Physician: ____

Name Address Phone#

Do you want this consult sent to your referring Physician? Yes / No (If so please include Fax #)___________________________

CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS:

Is this a new injury that you have not been seen for before? Yes / No

Body part injured: ( ) Left ( ) Right ____

Date of injury / accident / onset: ______________________________Cause: Sports / Work / MVA / Other

How did the injury occur? ____

How does it effect / Bother you? ____

Pain at rest: (No Pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Worst pain imaginable)

Pain at activity: (No Pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Worst pain imaginable)

Does anything help decrease your pain? ____

Is this problem? Improving / Same / Worsening / Other ____

Are you in physical therapy? Yes / No, If yes where? ____

If you were/are unable to work/play list the dates of the disability: _______________________to __________________________

MEDICAL HISTORY:

List any changes to your medical history since your last visit: ____

List any medications since your last visit: ____

REVIEW OF SYSTEMS: (Check all that apply)

GENERAL
( ) weight change
( ) Fever or Chills
( ) Aids / HIV
( ) Night Sweats
( ) Bleeding
( ) Lumps or Masses
( ) Dizziness or Fainting
( ) Diabetes Mellitus
( ) Thyroid Problems
( ) Cancer

EAR-EYE-NOSE-THROAT
( ) Visual Change
( ) Hearing Change
( ) Tinnitus
( ) Bleeding Gums

MUSCULOSKELETAL
( ) Backache
( ) Joint Pain
( ) Joint Swelling

GASTROINTESTINAL
( ) Difficulty Swallowing
( ) Jaudice
( ) Hepatitis
( ) Reflux
( ) Ulcer

CARDIOVASCULAR
( ) Chest Pain
( ) Heart Disease
( ) High Blood Pressure
( ) Mitral Valve Prolapse
( ) Thrombohlebitis

RESPIRATORY
( ) Cough/Sputum
( ) Tuberculosis
( ) Shortness of Breath
( ) Asthma
( ) Emphysema

OTHER ILLNESS: ________________________________
( ) All Systems Reviewed & Negative

GENITOURINARY
( ) Urinary Infection
( ) Incontinence
( ) Urinary Frequency
( ) Veneral Disease
( ) Menopause

NEUROLOGIC
( ) Seizures
( ) Numbness
( ) Weakness

PSYCHOLOGICAL
( ) Depression
( ) Bipolar
( ) ADD/ADHA
( ) Other

SKIN
( ) Itching or Rash

PROVIDER NOTES

______________________________ __________ ______________________________ __________

PATIENT/GUARDIAN SIGNATURE **DATE** **** PHYSICIAN'S SIGNATURE **** **DATE**