



Stony Brook  
Medicine

DEPARTMENT OF MEDICINE  
Outpatient Intake Form

Patient Name: \_\_\_\_\_

MR#: \_\_\_\_\_

DATE: \_\_\_\_\_

NAME:

\_\_\_\_\_ Last

\_\_\_\_\_ First

\_\_\_\_\_ Middle Initial

Date of Birth: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME \_\_\_\_\_

WORK \_\_\_\_\_

PHONE: \_\_\_\_\_

PHONE: \_\_\_\_\_

Did someone refer you here?  Yes  No If yes, please give name: \_\_\_\_\_

Main reason for your visit today: \_\_\_\_\_

**MEDICAL HISTORY:** (Please check  all that apply, and feel free to elaborate under "Additional Information")

<input type="checkbox"/> heart disease	<input type="checkbox"/> emphysema	<input type="checkbox"/> dementia	<input type="checkbox"/> sexually transmitted disease/herpes
<input type="checkbox"/> osteoporosis	<input type="checkbox"/> asthma	<input type="checkbox"/> frequent urinary tract infections or incontinence	
<input type="checkbox"/> heart failure	<input type="checkbox"/> chronic bronchitis	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> heart murmur	<input type="checkbox"/> pneumonia	<input type="checkbox"/> liver disease	<input type="checkbox"/> polio
<input type="checkbox"/> coronary heart disease	<input type="checkbox"/> hay fever/allergies	<input type="checkbox"/> jaundice/hepatitis	<input type="checkbox"/> kidney stones
<input type="checkbox"/> rheumatic fever	<input type="checkbox"/> diabetes	<input type="checkbox"/> thyroid disease	<input type="checkbox"/> kidney disease
<input type="checkbox"/> rheumatic heart disease	<input type="checkbox"/> stroke	<input type="checkbox"/> depression or anxiety	<input type="checkbox"/> prostate disease
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> seizure	<input type="checkbox"/> gall bladder disease	<input type="checkbox"/> colitis
<input type="checkbox"/> high cholesterol	<input type="checkbox"/> anemia	<input type="checkbox"/> glaucoma	<input type="checkbox"/> diverticulitis
<input type="checkbox"/> arthritis	<input type="checkbox"/> bleeding disorder	<input type="checkbox"/> cataracts	<input type="checkbox"/> hemorrhoids
<input type="checkbox"/> sciatica	<input type="checkbox"/> gout	<input type="checkbox"/> fracture	<input type="checkbox"/> ulcers
<input type="checkbox"/> Alcohol/substance abuse	<input type="checkbox"/> Parkinson's Disease		<input type="checkbox"/> head injury
<input type="checkbox"/> cancer (describe): _____	<input type="checkbox"/> blood transfusion (year: _____ )		<input type="checkbox"/> hernia

ADDITIONAL INFORMATION/OTHER CONDITIONS:



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**HAVE YOU RECENTLY NOTICED:** *(Please check ✓ all that apply)*

<input type="checkbox"/> fatigue	<input type="checkbox"/> headaches/migraines	<input type="checkbox"/> change in bowel habits	<input type="checkbox"/> vaginal/penile discharge
<input type="checkbox"/> weight gain/loss	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> joint swelling or pain	<input type="checkbox"/> frequent urine infections
<input type="checkbox"/> appetite changes	<input type="checkbox"/> bronchitis/chronic cough	<input type="checkbox"/> swollen ankles	<input type="checkbox"/> blood in urine
<input type="checkbox"/> change in hearing	<input type="checkbox"/> asthma/wheezing	<input type="checkbox"/> leg pain	<input type="checkbox"/> change in urinary habits
<input type="checkbox"/> ringing in ear(s)	<input type="checkbox"/> chest pain	<input type="checkbox"/> varicose veins/phlebitis	<input type="checkbox"/> easy bruising
<input type="checkbox"/> change in ability to exercise	<input type="checkbox"/> palpitations/irregular pulse	<input type="checkbox"/> persistent nausea/vomiting	<input type="checkbox"/> painful or heavy vaginal bleeding
<input type="checkbox"/> fainting spells/passing out	<input type="checkbox"/> sinus trouble	<input type="checkbox"/> heartburn/indigestion	<input type="checkbox"/> seizures
<input type="checkbox"/> failing vision	<input type="checkbox"/> frequent sore throat	<input type="checkbox"/> chronic abdominal pain	<input type="checkbox"/> tremor/hands shaking
<input type="checkbox"/> eye pain, redness	<input type="checkbox"/> hay fever/allergies	<input type="checkbox"/> jaundice/hepatitis	<input type="checkbox"/> numbness/tingling
<input type="checkbox"/> double or blurred vision	<input type="checkbox"/> prolonged hoarseness	<input type="checkbox"/> diarrhea/constipation	<input type="checkbox"/> muscle weakness
<input type="checkbox"/> eye infections	<input type="checkbox"/> difficulty swallowing	<input type="checkbox"/> bloody stools	<input type="checkbox"/> recurrent back pain
<input type="checkbox"/> mouth sores	<input type="checkbox"/> rashes/hives	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> cold/numb feet
<input type="checkbox"/> recurrent nose bleeds	<input type="checkbox"/> eczema/psoriasis	<input type="checkbox"/> dizzy spells	<input type="checkbox"/> foot pain
<input type="checkbox"/> depression/nervousness	<input type="checkbox"/> falls/unsteady walking	<input type="checkbox"/> memory loss	<input type="checkbox"/> recent hair loss
<input type="checkbox"/> insomnia	<input type="checkbox"/> loud snoring	<input type="checkbox"/> swollen glands	<input type="checkbox"/> incontinence ( <i>urine or stool</i> )

**HOSPITALIZATIONS:**

Reason for Hospitalization	Hospital	Date(s)

**SURGERIES:**

Surgical Procedure	Hospital	Date(s)



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**CURRENT MEDICATIONS:** *(Include prescriptions, vitamins, herbals, and over-the-counter medications)*

Name of Drug	Dose (Strength)	Times/Day

**ALLERGIES:** *(include allergies to medications, dyes, contrast material)*

DRUG	REACTION

**SOCIAL HISTORY:**

Occupation: \_\_\_\_\_

If you are retired, what date did you retire? \_\_\_\_\_

Do you live alone? \_\_\_\_\_ Or with others (please list)? \_\_\_\_\_

Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_ For how long? \_\_\_\_\_

If you are a former smoker, when did you quit? \_\_\_\_\_

Alcohol use:  Yes  No If yes, amount: \_\_\_\_\_

Do you exercise?  Yes  No If yes, what type? \_\_\_\_\_

How often? \_\_\_\_\_

Do you use illicit substances?  Yes  No

Baby boomers (those born between 1945 and 1965) make up 75% of Hepatitis C virus cases in the U.S. Most people with Hepatitis C don't know they are infected. Hepatitis C is a virus that is now curable.

If you were born between 1945 and 1965, please check this box if you do NOT want to be screened for Hepatitis C

**FAMILY HISTORY:** List diseases each may have had *(Especially Diabetes, cancer, heart disease, dementia and strokes)*

Mother:	
Father:	
Brother(s):	
Sister(s):	
Child(ren):	
Grandparents:	

**WHEN WAS YOUR LAST:**

Dental Visit: \_\_\_\_\_

Ophthalmology Visit (eye doctor): \_\_\_\_\_



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**HAVE YOU EVER HAD:**

Flu Vaccine:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____
Pneumonia Vaccine:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____
Tetanus Shot:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____
Tetanus Diphtheria Pertusis Vaccine:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____
Shingles Vaccine:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____
Colonoscopy/Fex Sigmoidoscopy: <i>(Rectal scope to screen for colon cancer)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____
Stool Card test for blood:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____
Bone Mineral Density:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____

**FOR WOMEN ONLY:**

When did menopause begin? \_\_\_\_\_

Since then, have you noticed any vaginal bleeding?  Yes  No

Do you take Calcium and Vitamin D supplements?  Yes  No Dose: \_\_\_\_\_

Are you on hormone replacement therapy?  Yes  No Medication: \_\_\_\_\_

Date of last PAP test \_\_\_\_\_ Result (normal or abnormal): \_\_\_\_\_

Have you ever had a mammogram?  Yes  No If so, when was it last done? \_\_\_\_\_

Childbirth-Related: *Please give the number of:*

Pregnancies: \_\_\_\_\_ Children: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_

**FOR MEN ONLY: Have you ever had...**

Rectal exam (digital/finger)?  Yes  No If so, when? \_\_\_\_\_

A PSA (Prostate Specific Antigen) blood test?  Yes  No If so, result? \_\_\_\_\_

**DIETARY HISTORY:**

Usual Adult Weight: \_\_\_\_\_ Any change in weight in the past 6 months?  Yes  No

Appetite:  Good  Fair  Poor

Are you on a special diet? \_\_\_\_\_

Any food allergies? List: \_\_\_\_\_

**Functional History:**

Do you have any physical handicaps that limit your daily activities?  No  Yes, describe \_\_\_\_\_

How much pain have you had over the past month?  None  Some - mild to moderate  Severe



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**OTHER CONCERNS:**

Has anyone close to you physically/emotionally/financially hurt or abused you?  Yes  No

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling Down, depressed or hopeless	0	1	2	3

Please list the names and telephone numbers of other physicians who take care of your medical problems (e.g., psychiatrist, ophthalmologist, gynecologist, urologist, etc.):

Name	Specialty	Telephone Number

Please list the name and telephone number of the person you would like us to contact in the event of an emergency:

\_\_\_\_\_

Whom would you want to make medical decisions for you if you were unable to do so? (Health Care Proxy):  
(Name, Address, and Phone Number): \_\_\_\_\_

Completed by: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by (physician): \_\_\_\_\_ MD ID#: \_\_\_\_\_ Date: \_\_\_\_\_