Stony Brook Medicine

OPKAR CHAWLA, MD
ELIZABETH JEREMIAS, MD
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STONYBROOKEXTENDEDCARE.COM

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

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 (check 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: _____

_____

_____

_____

_____