STONY BROOK ORTHOPAEDIC ASSOCIATES DIVISION OF SPORTS MEDICINE

Stony Brook Medicine

SB Sports Medicine

Stony Brook University Orthopaedics

Patient Follow-Up Information Form

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 a note or letter sent to them? YES/NO)*

COACH:_____
NAME ADDRESS PHONE # *(Do you want a note or letter sent to them? YES / NO)*

ATHLTIC TRAINER:_____
NAMES SCHOOL/TEAM PHONE # *(Do you want a note or letter sent to them? YES / NO)*

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_____

HAND DOMINANCE ☐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 DATES OF DISABILITY:_____to_____

MEDICAL HISTORY:

LIST ANY CHANGES TO YOUR MEDICAL HISTORY SINCE YOUR LAST VISIT:_____

_____

LIST ANY NEW 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 PROBLEM
[ ] 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

GENITOURINARY
[ ] URINARY INFECTIONS
[ ]INCONTINENCE
[ ] URINARY FREQUENCY
[ ] VENERAL DISASE
[ ] MENOPAUSE

NEUROLOGIC
[ ] SEIZURES
[ ] NUMBNESS
[ ] WEAKNESS

PSYCHOLOGICAL
[ ] DEPRESSION
[ ] BIPOLAR
[ ] ADD/ADHD
[ ] OTHER

SKIN
[ ] ITCHING OR RASH

OTHER ILLNESS :_____
[ ] ALL SYSTEMS REVIEWED & NEGATIVE

PROVIDER NOTES SECTION:

_____ _____ _____ _____
PATIENT/GUARDIAN SIGNATURE DATE **PHYSICIAN'S SIGNATURE** DATE
(I HAVE REVIEWED AND DISCUSSED THE ABOVE WITH THE PATIENT.)