

SB Sports Medicine



Stony Brook University Orthopaedics Patient Follow-Up Information Form

NAME:		DOB:	TOI	DAY'S DATE:	
	T M.I.				
WORK/SPORTS STATUS: Ful	Il Time / Part Time / Injured /	Disabled / Stu	dent / Retired	1 / Playing Sports	
	•			• • •	
CURRENT SCHOOL:	DE SCHOOL &GRADE/LEVEL	51 01112, 000	01111101W <u>-</u>	INCLUDE POSITIONS PLAYED	
REFERRING PHYSICIAN:					
	NAME	ADDRESS	PHONE #	(Do you want a note or letter sent to them? YES/NO)	
COACH:	NAME	, DDDDEGG	PYLONE #		
		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)	
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CHIEF COMPLAINT / HIST	ORY OF PRESENT ILLNI	ESS:			
IS THIS A NEW INJURY THA			EFORE? YES	S / NO	
BODY PART INJURED: □LE	FT□RIGHT				
HAND DOMINANCE □LEFT	□RIGHT				
DATE OF INJURY/ACCIDEN	T/ONSET:		CAUSE: SE	ORTS/WORK/MVA/OTHER	
HOW DID THE INJURY OCC					
HOW DOES IT EFFECT / BOT					
PAIN AT REST: (No Pain) 0 –	1-2-3-4-5-6-7-8-	- 9 – 10 (Wors	Pain Imagin	able)	
PAIN AT ACTIVITY: (No Pair	a) $0 - 1 - 2 - 3 - 4 - 5 - 6 - 7$	7 - 8 - 9 - 10	Worst Pain Ir	naginable)	
DOES ANYTHING HELP DEC	CDEACE VOLID DAIN?			_	
					
IS THIS PROBLEM? IMPROV					
	E TO WORK/PLAY LIST DA	ATES OF DISA	ABILITY:	to	
MEDICAL HISTORY:					
LIST ANY CHANGES TO YO	UR MEDICAL HISTORY S	INCE YOUR	LAST VISIT:		
LIGE ANN NEW MEDICATIO		CIT.			
LIST ANY NEW MEDICATIO		SIT:			
	NS SINCE YOUR LAST VI	SIT:			CTION
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