Stony Brook Medicine

DEPARTMENT OF MEDICINE

Outpatient Intake Form

Patient Name: _____

MR#: _____

DATE: _____

NAME: _____
Last First Middle Initial

Date of Birth: _____

ADDRESS: _____

HOME PHONE: _____

WORK 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")*

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

ADDITIONAL INFORMATION/OTHER CONDITIONS:

Stony Brook Medicine

DEPARTMENT OF MEDICINE

Outpatient Intake Form

Patient Name: _____

MR#: _____

DATE: _____

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

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

HOSPITALIZATIONS:

Reason for Hospitalization	Hospital	Date(s)

SURGERIES:

Surgical Procedure	Hospital	Date(s)

Stony Brook Medicine

DEPARTMENT OF MEDICINE

Outpatient Intake Form

Patient Name: _____

MR#: _____

DATE: _____

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):

Stony Brook Medicine

DEPARTMENT OF MEDICINE

Outpatient Intake Form

Patient Name: _____

MR#: _____

DATE: _____

HAVE YOU EVER HAD:

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

Stony Brook Medicine

DEPARTMENT OF MEDICINE

Outpatient Intake Form

Patient Name: _____

MR#: _____

DATE: _____

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: _____