

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			
<i>Condition / Disease</i>	<i>Year Began</i>	<i>Condition / Disease</i>	<i>Year Began</i>
<input type="checkbox"/> Hypertension		Other(s):	
<input type="checkbox"/> High Cholesterol			
<input type="checkbox"/> Hyper/Hypothyroidism			
<input type="checkbox"/> COPD, Emphysema or Asthma			
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> GERD			
<input type="checkbox"/> Depression or Anxiety			
<input type="checkbox"/> Heart Conditions			

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures			
<i>Operation / Hospitalization / Injury</i>	<i>Month / Yr</i>	<i>Operation / Hospitalization / Injury</i>	<i>Month / Yr</i>

Other Physicians and Specialists
<i>List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc.)</i>

Medication/Food Allergies or Intolerances			
<i>List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)</i>			
<i>Medication / Food</i>	<i>Reaction</i>	<i>Medication / Food</i>	<i>Reaction</i>

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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 <input type="checkbox"/>	No <input type="checkbox"/>
Colonoscopy		Abnormal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mammography		Abnormal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pap Smear		Abnormal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bone Density		Abnormal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dental Exam				
Eye Exam				

Vaccinations	
	Date
Tetanus (Tdap)	
Influenza	
Pneumovax (Pneumonia)	
Zostavax (Shingles)	

Current Medications			
Medication	Dosage	Medication	Dosage

Social, Educational and Work History

Marital Status:	
Work Status (check one): Employed <input type="checkbox"/> / Unemployed <input type="checkbox"/> / Retired <input type="checkbox"/> / Disabled <input type="checkbox"/>	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: _____
