STONY BROOK SURGICAL ASSOCIATES

PATIENT ASSESSMENT FORM (new patients only)

Please complete all sections

Patient Information	HGT	WGT	SS#
Name (Last, First, MI)	DOB	Gender ☐Male ☐Female	
Home Phone	Work Phone	Cell Phone	
Gender ☐Male ☐Female	Occupation		
Religion	Race/Ethnicity		
Preferred Language	Interpreter? ☐No ☐Yes		
Name of Pharmacy	Phone		

Reason for Visit:_____

Do you have any pain related to your presenting complaint/condition? ☐No ☐Yes
(If yes, Pain Tool must be completed)

Social Habits ☐ N/A

Alcohol ☐No ☐Yes (frequency)_____	Cocaine ☐No ☐Yes	Narcotics/Drug Use ☐No ☐Yes
Smokes Tobacco ☐No ☐Yes	If Yes, # of Yrs _____ # of Packs/Day_____ When Stopped_____	
Is your child or others exposed to second hand smoke inside or outside of home? ☐No ☐Yes		
Current Health Care Proxy ☐No ☐Yes	Living Will ☐No ☐Yes	
Cultural & Religious Beliefs that May Affect Care ☐No ☐Yes _____		
Do you prefer to learn by ☐Seeing (TV, Video, Written) ☐ Hearing (Audio) ☐ Doing (Hands On)		
Do you have any barriers to learning (please check) ☐ Physical ☐ Emotional ☐ Vision ☐ Financial ☐ Hearing ☐ Cognitive		
Can you read and understand English? ☐No ☐Yes	What is your first language? _____	

Hospitalization/Surgery/Major Illness ☐ N/A

PROBLEM	YEAR	WHERE TREATED	DAYS IN HOSPITAL

Blood Transfusion ☐No ☐Yes Date: _____ Complications: _____

Gynecologic/Obstetric History (ENT patients do not need to complete) ☐ N/A

Any Pregnancies? ☐No ☐Yes (how many) _____	How many children have you given birth to?_____
How many abortions/miscarriages? _____	Going through menopause? ☐No ☐Yes
Date of last period _____	Monthly breast exams? ☐No ☐Yes
Lumps on breasts? ☐No ☐Yes	Date of last mammogram: _____

Medications (Please list all medications you are currently taking, including vitamins and supplements)

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

Previous Bleeding Problems? ☐No ☐Yes Herbal medications? ☐No ☐Yes

Allergies to Medication? ☐No ☐Yes (type of reaction) _____

Food Allergies? ☐No ☐Yes (please specify) _____

Nutritional Data

Are you following a special diet? ☐No ☐Yes _____

Unintentional Weight ☐ Over/Under 5 lbs in 1 month ☐ Over/Under 10 lbs in 3-6 months

Appetite ☐ Good (eat 3+ meals/day) ☐ Fair (1-2 meals/day) ☐ Poor (less than 1 meal/day)

NAME_____

MRN# _____

Personal/Family History (Check all that apply for patient and/or family member)

IF YES	PATIENT/HOW OFTEN	FAMILY MEMBER/HOW OFTEN
Allergies	☐ _____	☐ _____
Amputation	☐ _____	☐ _____
Anesthesia Problems	☐ _____	☐ _____
Angina	☐ _____	☐ _____
Anxiety or Depression	☐ _____	☐ _____
Asthma	☐ _____	☐ _____
Bleeding/Bruising Problems	☐ _____	☐ _____
Bowel Problems	☐ _____	☐ _____
Cancer	☐ _____	☐ _____
Chest Pain/Heart Disease	☐ _____	☐ _____
Diabetes Mellitis	☐ _____	☐ _____
Dizziness	☐ _____	☐ _____
Ear Problems	☐ _____	☐ _____
Eye Problems	☐ _____	☐ _____
Headaches	☐ _____	☐ _____
Heartburn	☐ _____	☐ _____
Hepatitis	☐ _____	☐ _____
High Blood Pressure	☐ _____	☐ _____
Hyperthermia/Hyperpyrexia (malignant)	☐ _____	☐ _____
Kidney Disease	☐ _____	☐ _____
Known Genetic Disorder	☐ _____	☐ _____
Mental Retardation/Illness	☐ _____	☐ _____
Moles that are changing	☐ _____	☐ _____
Nasal Problems	☐ _____	☐ _____
Pain in Joints/Limbs	☐ _____	☐ _____
Persistent Cough/Wheezing	☐ _____	☐ _____
Prostate Enlargement	☐ _____	☐ _____
Rashes, Sores, Itching	☐ _____	☐ _____
Ringing in Ears	☐ _____	☐ _____
Seizure Disorder	☐ _____	☐ _____
Shortness of Breath	☐ _____	☐ _____
Skin Problems	☐ _____	☐ _____
Stroke	☐ _____	☐ _____
Thyroid Problems	☐ _____	☐ _____
Trouble Sleeping	☐ _____	☐ _____
Tuberculosis/Lung Disease	☐ _____	☐ _____
Stomach/Leg Ulcers	☐ _____	☐ _____
Urination Problems	☐ _____	☐ _____
Weakness/Numbness	☐ _____	☐ _____
OTHER _____	☐ _____	☐ _____
☐ **CHECK IF NONE APPLY**	☐ _____	☐ _____

Personal/Social History

Residence ☐ Nursing Home ☐ Private Home ☐ Live Alone ☐ Apartment ☐ Shelter ☐ Other _____

Who will assist in your care ☐ Spouse ☐ Family ☐ Friend ☐ Self ☐ Other (name and phone)_____

Do others depend on you for their care? ☐No ☐Yes ☐N/A

Are you currently in a domestic violence situation? ☐No ☐Yes

COMPLETED BY: _____ DATE: _____

REVIEWED BY: _____ID # _____ DATE: _____