Stony Brook Medicine | Center for Vein Care

PATIENT ASSESSMENT FORM (new patients only)

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