STONY BROOK SURGICAL ASSOCIATES
PATIENT ASSESSMENT FORM (new patients only)
Please complete all sections

PATIENT INFORMATION HGT: _____ WGT: _____ SS#_____
Name:_____MRN # _____DOB_____
Address:_____
Tel # (h): _____Tel# (w):_____
Insurance Plan (primary):_____Ins #:_____
Insurance Plan (secondary):_____Ins #:_____
Insured Name: ☐ Self ☐ Other (indicate relation & name)_____
Primary MD:_____Address:_____Tel#:_____
Doctor Requesting Consult:_____
Address:_____Tel#_____
Status: ☐ N/A (child) ☐ Single ☐ Legally Married ☐ Divorced ☐ Separated ☐ Widow/er
Religion: _____Race/Ethnicity:_____ Preferred Language: _____
Interpreter: ☐ Yes ☐ No Occupation: _____
Next of Kin/Contact Emergency Person:_____
Tel #: _____ Relationship: _____
Name of Pharmacy: _____ Tel #: _____

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 ☐ Yes ☐ No Cocaine ☐ Yes ☐ No Narcotics/Drug Use ☐ Yes ☐ No
Smokes Tobacco: ☐ No ☐ Yes # Yrs _____ # 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 (pls check): ☐ physical ☐ emotional ☐ vision ☐ financial ☐ hearing ☐ cognitive
Can you read & understand English? ☐ Yes ☐ No What is your first language? _____

HOSPITALIZATION/SURGERY/MAJOR ILLNESS ☐ **N/A**

PROBLEM	YEAR	WHERE TREATED	DAYS IN HOSPITAL

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

GYNECOLOGIC/OBSTETRIC HISTORY (ENT Patients Do Not Need To Complete)
☐ **N/A** How many pregnancies? _____ How many children have you given birth to?_____
How many abortions or miscarriages? _____ Going thru menopause? ☐ No ☐ Yes
Date of Last period? _____ Examine breasts monthly? ☐ No ☐ Yes
Lumps on breasts? ☐ No ☐ Yes Date of Last Mammogram:_____

MEDICATIONS (Please list all medications you are currently taking, including vitamins & supplements)
1) _____ 6) _____
2) _____ 7) _____
3) _____ 8) _____
4) _____ 9) _____
5) _____ 10) _____
Allergies to Medications? ☐ No ☐ Yes Type of Reaction? _____
Type of Medications?_____
Herbal Medications? ☐ No ☐ Yes Previous Bleeding Problems? ☐ No ☐ Yes

OVER PLEASE

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

Specify (Name & Phone #): _____

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

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

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)

COMPLETED BY:_____DATE:_____

REVIEWED BY:_____ ID #_____ DATE:_____

(Print Name)