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	
☐ heart failure	☐ chronic bronchitis		☐ HIV/AIDS
☐ 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:

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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	☐ variscose 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)

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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: _____

Do you live alone or with others? _____

Do you smoke? ☐ Yes ☐ No If yes, how much?_____For how long? _____

Alcohol use: ☐ Yes ☐ No If yes, amount: _____

Do you exercise? ☐ Yes ☐ No If yes, what type? _____

How often?

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):

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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

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OTHER CONCERNS:

Has anyone close to you physically/emotionally/financially hurt or abused you?	☐ Yes	☐ No
Are there other issues you would like to discuss with your doctor today?	☐ Yes	☐ No

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: _____