Stony Brook Medicine

Stony Brook Medical Associates

NAME:		**DATE:**	
DATE OF BIRTH:	**AGE:**	**HEIGHT:**	**WEIGHT:**
Primary Care/Referring Physician:			

Present Illness: Please describe briefly in your own words why you are here today.

_____

_____

MEDICAL HISTORY: Please indicate if you have (or ever had) any of the following illnesses

EYES:	□ Change in Vision □ Blurred Vision □ Loss of Vision □ Eye Pain □ Eye Redness □ Cataracts □ No Problems □ Other:_____
ENT:	□ Nosebleeds □ Trouble Swallowing □ Frequent Sore Throat, Hoarseness □ Loss of Smell □ Hearing Loss/Ringing in ears □ Loss of Taste □ Sinus Pain □ No Problems □ Other:_____
CARDIOVASCULAR:	□ Heart Attack/Disease □ High Blood Pressure □ Palpitations (Fast/Irregular Heartbeat) □Chest Pain/Discomfort □ No Problems □ Other:_____
RESPIRATORY:	□ Cough/Wheeze □ Loud Snoring/Altered Breathing During Sleep (Sleep Apnea) □ Short of Breath □ COPD □ No Problems □ Other:_____
GASTROINTESTINAL:	□ Heartburn/Indigestion □ Blood or Change in Bowel Movement □ Constipation □ GERD □ No Problems □ Other:_____
GENITOURINARY:	□ Leaking Urine □ Blood in Urine □ Nighttime Urination or Increased Frequency □ No Problem □ Other:_____
MUSCULOSKELETAL:	□ Neck Pain □ Back Pain □ Muscle/Joint Pain □ Weakness □ Muscle Cramps □ Involuntary Muscle Twitching/Jerking □ No Problems □ Other:_____
SKIN:	□ New or Change in Mole □ Changes in Skin Coloration or Texture □ Rash/Itching □ No Problems □ Other:_____
NEUROLOGICAL:	□ Headache □ Seizures □ Stroke □ Memory Loss (Dementia) □ Fainting □ Dizziness/Vertigo □ Numbness/Tingling □ Unsteady Gait □ Incoordination/Clumsy □ Frequent Falls □ Concussions □ Slurred Speech □ Difficulty Finding Words □ Trembling/Tremor/Shaking □ No Problems □ Other:_____
PSYCHIATRIC:	□ Anxiety □ Stress □ Irritability □ Depression □ Sleep Problems □ Nervousness □ Tenseness □ Confusion □ Changes in Personality □ Suicidal Thoughts □ No Problems □ Other:_____
ENDOCRINE:	□ Thyroid Disease □ Diabetes □ Addison's Disease □ Cushing's □ Grave's Disease □ Hashimoto's □ Heat or Cold Sensitivity □ No Problems □ Other:_____

HEMATOLOGIC/ LYMPHATIC:	**□ Anemia/Hemophilia □ Easy Bruising □ Clotting/Bleeding Disorder □ Swollen Glands □ No Problems □ Other:_____**
ALLERGIES/ IMMUNOLOGICAL:	**□ Hay Fever/Seasonal Allergies □ Medication Allergies □ Food Allergies □ Frequent Infections □ No Problems *PLEASE LIST ALLERGIES IF ANY:_____**
INFECTIOUS/ OTHER DISEASES:	**□ Syphilis □ Polio □ Meningitis □ Tuberculosis □ Rheumatic Fever □ No Problems □ Other:_____**
GENERAL:	**□ Unexplained Weight Loss/Gain □ Unexplained Fatigue/Weakness □ Loss of Appetite □ Fever/Chills □ Swelling of Hands/Feet/Joints □ Unbalanced □ Sexual Dysfunction □ Changes in Hand Writing □ No Problems □ Other:_____**
OTHER: ex: Cancer, Hepatitis, Car Accident, Head Trauma etc.	

Please List Any Medications You are Currently Taking:

Medication Name	Dose	Medication Name	Dose

Please List Any Procedures or Surgeries:

Procedure Name	Approximate Date	Procedure Name	Approximate Date

Family Medical History:

Family Member	Illness(s)	Family Member	Illness(s)

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No ☐ Past. If Yes, how much do you smoke a day? _____If you quit how long ago?

_____ Do you drink alcohol? ☐ Yes ☐ No. If yes, what at kind and how often?_____

Are You Left or Right Hand Predominant? _____