Stony Brook Medicine

DEPARTMENT OF MEDICINE

Outpatient Intake Form

Patient Name: _____

MR#: _____

DATE: _____

LEGAL NAME: _____
Last First Middle Initial

PREFERRED NAME: _____ PREFERRED PRONOUN: He, She, They

Date of Birth: _____ SEX AT BIRTH: Male, Female, Other

Please circle one:

GENDER IDENTITY: Male, Female, Transgender (Male to Female, Female to Male), Non-binary, Genderqueer, Other, choose not to answer

Please circle one:

SEXUAL ORIENTATION: gay/lesbian, straight/heterosexual, bisexual, other, choose not to answer

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

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	☐ HIV/AIDS
☐ heart failure	☐ chronic bronchitis	☐ tuberculosis	☐ polio
☐ heart murmur	☐ pneumonia	☐ liver disease	☐ kidney stones
☐ coronary heart disease	☐ hay fever/allergies	☐ jaundice/hepatitis	☐ kidney disease
☐ rheumatic fever	☐ diabetes	☐ thyroid disease	☐ prostate disease
☐ rheumatic heart disease	☐ stroke	☐ depression or anxiety	☐ colitis
☐ high blood pressure	☐ seizure	☐ gall bladder disease	☐ diverticulitis
☐ high cholesterol	☐ anemia	☐ glaucoma	☐ hemorrhoids
☐ arthritis	☐ bleeding disorder	☐ cataracts	☐ ulcers
☐ sciatica	☐ gout	☐ fracture	☐ head injury
☐ Alcohol/substance abuse	☐ Parkinson's Disease	☐ blood transfusion (year:)	☐ hernia
☐ cancer (describe):			

ADDITIONAL INFORMATION/OTHER CONDITIONS:

Stony Brook Medicine

DEPARTMENT OF MEDICINE

Outpatient Intake Form

Patient Name: _____

MR#: _____

DATE: _____

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	☐ varicose 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)

Stony Brook Medicine

DEPARTMENT OF MEDICINE

Outpatient Intake Form

Patient Name: _____

MR#: _____

DATE: _____

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: _____

If you are retired, what date did you retire? _____

Do you live alone?_____ Or with others (please list)? _____

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

If you are a former smoker, when did you quit? _____

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

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

How often?

Do you use illicit substances? ☐ Yes ☐ No

SEXUAL ORIENTATION/IDENTITY: Bisexual, Gay, Heterosexual/Straight, Lesbian, Queer, Other

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):

Stony Brook Medicine

DEPARTMENT OF MEDICINE

Outpatient Intake Form

Patient Name: _____

MR#: _____

DATE: _____

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?	_____
COVID 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:

Last Menstrual Period: _____

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: _____

Complications of Child Birth: Hypertension, Diabetes, Blood Clots, Preeclampsia, Depression, Thyroid Disease, Other

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

Stony Brook Medicine

DEPARTMENT OF MEDICINE

Outpatient Intake Form

Patient Name: _____

MR#: _____

DATE: _____

OTHER CONCERNS:

Has anyone close to you physically/emotionally/financially hurt or abused you?	☐ Yes	☐ No

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling Down, depressed or hopeless	0	1	2	3

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: _____