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: _____