BIRCH TREE PODIATRY GROUP, PC.
FOOT AND ANKLE

NEW PATIENT RECORD

Name________________________________ Sex M ☐ F ☐ Date of Birth: ____/____/____

Work History

Are You currently employed? ☐ Yes ☐ No If so, present type of work________________
If not, are you: ☐ Retired ☐ Disabled ☐ Housewife ☐ Other, describe____________
In your work are you exposed to:
☐ Harmful toxins ☐ Heavy lifting ☐ Extremes in temperature
☐ Undue stress or pressure ☐ Other______________________________

Health Care Providers {What other health care providers have cared for you in the past five years?}

Year	Doctor	City & State
________	______________________________	______________________________
________	______________________________	______________________________

Current Medical Problems {list all medical issues and approximate date of onset}

Problem	Date of Onset
____	______________
____	______________
____	______________

Current Medications {List all medications you take including non-prescription}

1____________________ 3____________________ 5____________________

2____________________ 4____________________ 6____________________

Current Allergies or Sensitivities {Please answer **yes** or **no** to the following questions}

Have you ever had an allergy or reaction to: Penicilin________ Cortisone________
Aspirin________ Codeine_________ Novacaine_________ Sulfa Drugs_________
Any antibiotics_______________ Other______________________________________

Family Medical History

Relative	Age(s)	Good	Poor	Deceased
Father	_____	☐	☐	☐
Mother	_____	☐	☐	☐
Brother	_____	☐	☐	☐
Sisters	_____	☐	☐	☐
Spouse	____	☐	☐	☐
Children	_____	☐	☐	☐

Do you smoke? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No

Indicate if you or a member of your family has had any of the following: (**S** for self, **F** for family member)

__ Arthritis __ Asthma __ Bleeding disorder
__ Blood clots __ Diabetes __ Heart Diseases
__ Phlebitis __ Cancer __ Liver Diseases
__ Epilepsy __ Gout __ Kidney problems
__ High Cholesterol __ Lung problems
__ Thyroid problems __ Numbness
__ High Blood pressure __ Circulatory problems
__ Bypass surgery __ Mental Illness
__ Stomach or intestinal problems
__ Bone and/or joint Surgery
__ Heart Murmur

Patient signature:
____

Date: ______________________

Office use only: History updated (date)

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