Beth Israel Deaconess Medical Center

A teaching hospital of Harvard Medical School

Patient Sticker

NEW PATIENT MEDICAL HISTORY FORM

Division of Foot & Ankle Surgery

What is the reason for today's visit? _____

Who is your primary care physician? _____

Physician's address: _____

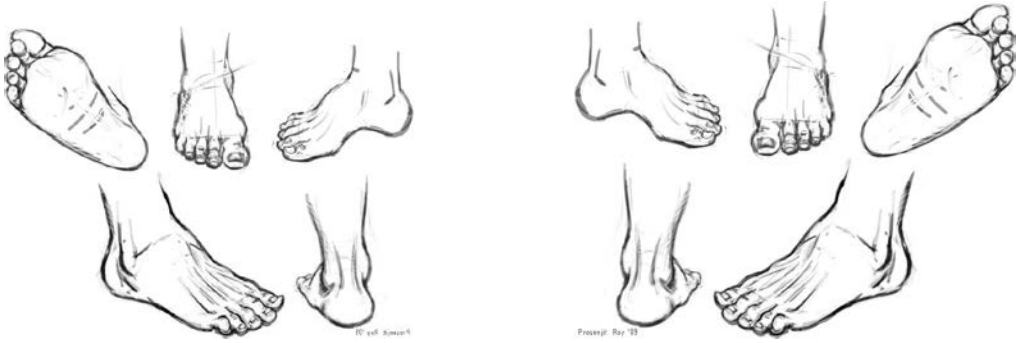
How were you referred to us? Physician □ Family member □ Friend □ Self □

To whom do you want copies of your office notes sent? _____

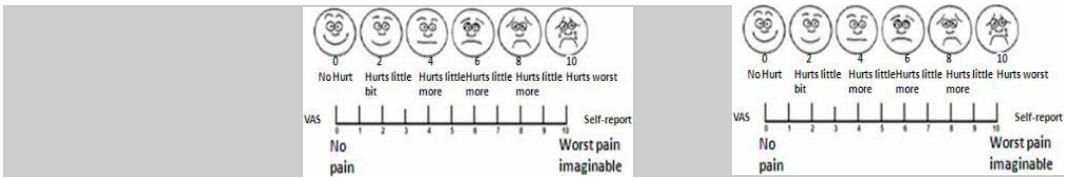
Is your visit today the result of a work injury? □ No □ Yes Date: _____/_____/_____

Are you currently represented by an attorney? □ No □ Yes Name: _____

Pain: Indicate the location of your pain on the diagram below with an X. Rate the severity.



RIGHT **LEFT**



At rest With activity

How long have you had this problem? _____ Date of injury: _____

Which activities make it worse? _____

Have you had any prior treatments for this? □ No □ Yes Type: _____

Medical History	No	Yes	Comments
Anemia/abnormal bleeding			
Asthma/allergies			
Heart disease/angina/chest pain			
High blood pressure			
Heart murmur/mitral valve prolapse			
Cancer			
Lung disease			
Diabetes			How many years?
Stomach disease/stomach ulcers			
Hepatitis/liver disease			
Kidney disease			
Thyroid			
Seizures/epilepsy/stroke			
Depression/anxiety			
Other psychiatric condition			
HIV or AIDS			

Surgical History:	
Procedure	Date

List all medications you are currently taking: *Include prescription drugs, inhalers, aspirin products, non-steroidal anti-inflammatories, eye drops, herbal/nutritional supplements, vitamins, over-the-counter medications and non-prescription drugs.*

Medication/Drug name	Dose/Route	Time/Frequency	Reason for Medication

List all allergies, sensitivities and medication reactions: *Include medications, vaccinations, foods, insects/venom (e.g. bee stings), substances (e.g. latex), environmental or seasonal allergies, reactions including iodine or radiology contrast material.*

□ **I have no allergies, sensitivities or medication reactions.**

Allergy/Sensitivity/Medication	Type of Reaction

Social History:

Are you currently working? □ No □ Yes Occupation: _____

Tobacco use: □ Never used

□ Current user or used within one month of this admission

□ Stopped more than one month ago but less than one year ago

□ Former user – stopped more than one year ago

Do you drink alcohol? □ No □ Yes Amount weekly: _____ Amount monthly: _____

Family History: *Has anyone in your immediate family had the following?*	No	Yes	Comments
Cancer			
Diabetes			
Heart disease			
Lung disease			
Kidney disease			
Skin disease (e.g. skin cancer)			
Blood disorders			
Gastrointestinal problems			

Review of Systems:		No	Yes	Comments
Constitutional	Are you currently in good health?			
	Have you had recent weight loss?			
Skin	Do you have any rashes or ulcers?			
Eyes	Do you wear glasses or contacts?			
	Do you have trouble with red swollen eyes?			
Ears/Nose/Throat	Do you have trouble swallowing?			
	Do you wear hearing aids?			
Cardiovascular	Do you have swelling in your ankles?			
	Do you have palpitations?			
Respiratory	Do you wheeze?			
Gynecological	Are you pregnant?			
	Date of last menstrual period ___/___/___			
	Are you breast feeding?			
Genitourinary	Do you have any problems with urination?			
Gastrointestinal	Do you have abdominal pain?			
	Have you had a change in bowel habits?			
Psychiatric	Do you feel anxious or depressed?			
Endocrine	Are you experiencing increased thirst or sweating?			
Hematology	Do you bruise easily?			
	Do you have painful or enlarged glands?			
	Do you have frequent headaches?			

Patient Certification:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes on my medical status.

X_____ or X _____ and _____ ___/___/___

Patient's signature | Person authorized to sign for patient | Relationship to patient | Date

Physician Review: I have reviewed the above information with the patient

X _____D.P.M. _____ D.P.M. ___/___/___ __ __ __ __

Physician signature | Print name | Date | Time

THIS SECTION TO BE COMPLETED BY MEDICAL ASSISTANT

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Temp: _____

Created: 3/1/2014