BAY AREA PODIATRY GROUP
Surgical and Non-Surgical Foot/Ankle Care

New Patient Form

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Last Visit w/PCP: _____

Endocrinologist: _____ Last Visit w/Endo: _____ Referred By: _____

Please describe your problem (include date of injury if applicable): _____

_____

_____

_____

PAST MEDICAL HISTORY

Check all that apply:

☐	Frequent Headache/Migraine	☐	Anemia / Blood Disorders
☐	Rheumatic Fever	☐	Pneumonia
☐	Kidney Disease	☐	Drug/Alcohol Abuse
☐	Dialysis MWF or T TH Sa	☐	Epilepsy / Seizures
☐	Diabetes Average Blood Sugar:	☐	Prolonged Bleeding Time
☐	Tuberculosis	☐	Stomach Disorder
☐	Emphysema	☐	Thyroid / Parathyroid Disease
☐	Heart Trouble	☐	High Blood Pressure
☐	Stroke	☐	Arthritis
☐	Chest Pain on Mild Exertion	☐	Psychiatric Treatment
☐	Gout	☐	Emotional Problems / Tension
☐	BLOOD CLOTS	☐	Asthma / Hay Fever / Shortness of Breath
☐	Tumor / Abnormal Growth / Cancer	☐	Prostate Disorder
☐	Ear / Nose / Throat Disorder	☐	Sexually Transmitted Disease

Has any FAMILY MEMBER had any of the following problems (Please indicate relationship):

Cancer: _____ Diabetes: _____ Heart Trouble: _____

High Blood Pressure: _____ Kidney Disease: _____ Stroke: _____

Mental or Emotional Disease: _____ Tuberculosis: _____

Arthritis: _____ Emphysema: _____ BLOOD CLOTS: _____

PATIENT INFORMATION

Do you currently smoke? ☐ No ☐ Yes If yes, how many packs /day? _____ How many years? _____

Smoke previously? ☐ No ☐ Yes If yes, how many packs/day? _____ How many years? _____ Year Quit: _____

Number of caffeine drinks per day: _____ Amount of alcohol consumed per week? _____

Please complete the following:

Height: _____ Weight: _____ Shoe Size: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Exercise Type/Duration/ Frequency (Example: Walk 10 minutes 3X per week): _____

_____

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ALLERGIES

Please check all allergies:

☐ Medications: _____

☐ Foods: _____

☐ Tapes ☐ Novocain ☐ Anesthetics ☐ Silver/Nickel/Costume Jewelry ☐ Other: _____

What types of reactions have you experienced? _____

_____

MEDICATIONS

Please list all prescription and over-the-counter medications and the dosages: _____

_____

_____

_____

_____

SURGICAL HISTORY

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

HEALTH REVIEW

Please select any symptoms you have had in the past 3 months:	
General	☐ Fever ☐ Chills ☐ Fatigue ☐ Weight Loss ☐ Weight Gain
Head	☐ Headaches ☐ Visual Problems ☐ Hearing Problems ☐ Light Sensitivity
Cardiovascular	☐ Chest Pain ☐ Palpitations ☐ Dizziness ☐ Swelling of Legs ☐ Other_____
Hematology	☐ Anemia ☐ Abnormal Bleeding/Bruising ☐ Blood Clots ☐ Other Blood Disorder_____
Respiratory	☐ Persistent Cough ☐ Wheezing ☐ Shortness of Breath
Gastrointestinal	☐ Difficulty Swallowing ☐ Indigestion/Heartburn ☐ Abdominal Pain ☐ Change in Bowel Habits
Urinary	☐ Painful Urination ☐ Frequent Night-time Urination ☐ Bladder Leakage ☐ Other_____
Musculoskeletal	☐ Join Pain/Swelling/Stiffness ☐ Back Pain ☐ Arthritis ☐ Muscle Weakness
Skin	☐ Skin Rash ☐ Suspicious Lesions ☐ Itching
Neurological	☐ Numbness of hands/feet ☐ Seizures ☐ Tremors ☐ Paralysis
Psychiatric	☐ Depression ☐ Anxiety ☐ Problems Sleeping ☐ Memory Loss
Endocrine	☐ Heat/Cold Intolerance ☐ Hot Flashes ☐ Change in hair/skin texture ☐ Other_____

The information provided here is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail, or phone by either physician or hospital. Also, I hereby authorize the doctor or her assistants to initiate the diagnosis and treatment of my condition with x-ray, examination, or photographs of infections as necessary.

Patient Signature: _____ Date: _____

I have personally reviewed the above information:

Physician Signature: _____ Date: _____