Birch Tree Medical Associates

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NEW PATIENT REGISTRATION FORM

To our new patients: To help us establish you with the best of care, please provide us with your complete health history including all Physical and Mental symptoms.

Personal History **Date** _____

Name: _____Date of Birth_____/_____/_____Age_____

Address _____

Social Security Number_____ Cell Phone_____

Home Phone_____ E-mail_____

Referred by_____

Please list names of doctors involved in you care

1.) _____

2.) _____

3.) _____

MAIN PROBLEMS/ REASONS FOR THIS CONSULTATION: (if possible, rank in terms of importance to you)

1. _____
2. _____
3. _____

Please list any allergies /reaction you have (drugs and other substances):

	Drug/Substance	**Reaction**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Please list ALL medications/supplements you are taking:

1._____ 2. _____

3._____ 4. _____

5._____ 6. _____

Pharmacy_____ **Tel:**_____

PAST MEDICAL, SURGICAL & TRAUMA HISTORY **Patient Name:**

List prior illness, injury, hospitalization, surgery, and/or trauma:

Reason: **Date/Month and Year**

_____

_____

_____

_____

_____

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
Other							

SOCIAL HISTORY (check those that apply): **Patient Name:**

Marital status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Education level completed:
- ☐ high school
- ☐ college
- ☐ professional school
- ☐ other:

Living arrangement:
- ☐ Alone
- ☐ family
- ☐ significant other

Pertinent travel history :(out of USA, epidemic areas)

_____

_____

LIFESTYLE / SELF-CARE ISSUES

Do you smoke cigarettes? ☐ YES ☐ NO If yes, how many? #_____yrs. _____ packs per day

Did you ever smoke? ☐ YES ☐ NO If yes, when did you quit? _____

Do you drink alcohol? ☐ YES ☐ NO If yes, how much? Type_____ & _____ drinks per week

Do you drink caffeine beverages? ☐ YES ☐ NO If yes, which? _____

Do you use recreational drugs? ☐ YES ☐ NO If yes, which? _____

Do you manage stress well? ☐ YES ☐ NO ☐ NOT SURE ☐ NEED HELP

Do you exercise regularly? ☐ YES ☐ NO If no, why? _____

Do you sleep soundly? ☐ YES ☐ NO If no, why? _____

Is your diet healthy enough? ☐ YES ☐ NO ☐ NOT SURE ☐ NEED HELP

**Do you wish to be tested for HIV/AIDS? ☐ YES ☐ NO

Have you ever been exposed to hazardous material (chemicals,asbestos,etc)? ☐ YES ☐ NO ☐ NOT SURE

DEVICES

Do You Use:

___Eyeglasses _____Contact Lens _____Hearing Aid _____Dentures

___Brace (Neck, Back) _____ Pacemaker _____ IUD, Diaphragm _____Artificial Limbs

REVIEW OF SYSTEMS **Patient Name:**

Check any symptoms that currently apply to you:

Constitutional
- ☐ poor appetite
- ☐ fevers
- ☐ chills
- ☐ weight loss
- ☐ weight gain
- ☐ fatigue

Eyes
- ☐ eye pain
- ☐ blurred vision
- ☐ poor vision(day)
- ☐ poor vision (night)
- ☐ wear corrective lenses
- ☐ near /far sighted
- ☐ Other

Ears, Nose
- ☐ ringing ears
- ☐ nosebleed/polyp
- ☐ postnasal drip
- ☐ sinus problems
- ☐ trouble with taste/smell
- ☐ poor hearing
- ☐ earaches/infections
- ☐ sneezing/discharges

Immune System
- ☐ too many infections
- ☐ allergies to food
- ☐ allergies to environment
- ☐ other concerns

Blood System
- ☐ lymph gland swelling
- ☐ diabetes
- ☐ anemia
- ☐ Hepatitis A/B/C
- ☐ HIV

Reproductive
- ☐ age started____
- ☐ # of pregnancies ___
- ☐ # of abortions___
- ☐ # of miscarriages___
- ☐ # of live births

Mouth, Throat
- ☐ tongue discoloration
- ☐ bad breath
- ☐ teeth problems
- ☐ tonsillitis/adenoids
- ☐ facial pain
- ☐ sore throat
- ☐ ulceration tongue
- ☐ gum bleeding

Heart & Circulation
- ☐ chest pain
- ☐ lightheadedness
- ☐ palpitations
- ☐ cold hands/feet
- ☐ fainting
- ☐ swelling feet
- ☐ blood clots
- ☐ varicose veins
- ☐ deep vein thrombosis

Breathing & Lungs
- ☐ shortness of breath
- ☐ wheezing or asthma
- ☐ repeating colds/flu
- ☐ dry cough/irritating

Sexual Organs
- ☐ sores on genitals
- ☐ lumps or swelling
- ☐ erection problems
- ☐ infertility
- ☐ repeated infections
- ☐ aversion to sex

Urine, Kidney, Bladder
- ☐ painful urination
- ☐ difficulty urinating
- ☐ kidney stones
- ☐ incontinence
- ☐ sudden urge
- ☐ blood/pus in urine
- ☐ UTI (Urinary Tract Infection

Muscles, Bones, Joints
- ☐ neck pain
- ☐ back pain
- ☐ muscle pain
- ☐ painful joints
- ☐ shoulder/elbow
- ☐ hip, knee, ankles
- ☐ wrist, fingers
- ☐ joint swelling
- ☐ muscle weakness
- ☐ muscle cramps

Skin, Hair
- ☐ psoriasis
- ☐ warts
- ☐ freckles
- ☐ itching, hives
- ☐ hair loss
- ☐ dry skin, eczema

Nerves, Movement, Brain
- ☐ seizures
- ☐ nerve pain
- ☐ poor balance
- ☐ poor coordination
- ☐ tremors or shaking
- ☐ headaches

Women
- ☐ pelvic pain
- ☐ vaginal discharge
- ☐ painful periods
- ☐ hot flashes
- ☐ Itching or soreness
- ☐ irregular menses
- ☐ leucorrhoea

Digestion & Intestines
- ☐ difficulty swallowing
- ☐ heartburn/ulcer
- ☐ nausea
- ☐ liver problems
- ☐ vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ abdominal pain
- ☐ hemorrhoids/piles
- ☐ blood in stool
- ☐ c.diff

This history record has been designed to facilitate our patients to assess their health issues in detail.
Once looked over this history record and reports, we will be asking you specific questions pertaining to your symptoms to get a complete disease picture. A complete case record thus created will be analyzed. This is a confidential record and will be kept in the office. Information contained here will not be released to anyone without your authorization to do so.

_____ _____

Patient/ Guardian signature that filled out the history **Date**

Phone – Home _____ **Cell** _____

E-mail _____