Broderick Podiatry – Patient Information Update Form

Broderick Podiatry has implemented an Electronic Medical Records system. To ensure we have your most up to date medical information, we are requiring all patients to complete this form annually.

Name: _____ **Date of Birth**: ___/___/____ **Gender:** M / F

Marital Status: please circle one: Single/Married/Domestic Partner/Separated/Divorced/Widowed

Primary Health _____/#_____
Insurance Company Name **ID Letters and Number**

Subscriber Name (ex. Spouse, Parent) and Date of Birth: _____/_____
Name **DOB**

Secondary Health Insurance: _____/#_____
Insurance Company Name **ID Letter and Number**

Subscriber Name (ex. Spouse, Parent) and Date of Birth: _____/_____
Name **DOB**

Primary Care Physician: _____ **Last seen (approx.):** _____

Current Medications:

(If you brought in a list with you, we can make a photo copy)

NAME OF MEDICATION	DOSAGE	# OF TIMES A DAY

Height: _____ **Weight:** _____ **Recent Blood Pressure:** _____**Tetanus Vaccine:** _____

MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY):

Diabetes High Blood Pressure Shortness of Breath Rheumatic Fever Stomach Ulcer

Difficulty healing when cut Heart Disease Gout Cancer Stroke Hepatitis Other_____

ALLERGY/REACTION TO ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY):

Cortisone/Penicillin/Latex/Codeine/Novocain/Adhesive Tape/Aspirin/Morphine/Iodine/Sulfa Antibiotic

Do you currently have an infection? Yes No

Please list any **major surgeries** you have had in the past yea**r:** _____

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SIGNATURE **DATE**