WELCOME

PATIENT INFORMATION

TODAY'S DATE_____ ALBERTA HEALTH #_____

LAST NAME_____FIRST_____MI_____

BIRTHDATE (MM/DD/YYYY)_____ SEX(PLEASE CIRCLE): M F MARITAL STATUS: M S D W

ADDRESS_____CITY_____PROV_____POSTAL_____

PATIENT EMPLOYER/SCHOOL_____OCCUPATION_____

HOW WERE YOU REFERRED TO OUR OFFICE (PLEASE CIRCLE): DOCTOR_____, FRIEND, FAMILY MEMBER, YELLOW PAGES, CLOSE TO HOME/WORK, INTERNET, OTHER_____

CONTACT INFORMATION

HOME PHONE (_____) _____ WORK/CELL (_____) _____

EMAIL_____ BEST TIME AND METHOD TO REACH YOU_____

IN CASE OF EMERGENCY, CONTACT

NAME_____ RELATIONSHIP_____

HOME (_____)_____ WORK/CELL (_____)_____

PODIATRIC HISTORY

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU CAME TO BE TREATED? (INCLUDE FOOT, ANKLE, KNEE, THIGH, AND HIP COMPLAINTS)_____

_____

_____

_____

_____

_____

HAVE YOU EVER BEEN TREATED BY A PODIATRIST BEFORE?

☐ YES ☐ NO

IF YES, PLEASE LIST NAME

_____

LAST VISIT

_____

IS THERE ANY PERSONAL OR FAMILY HISTORY OF DIABETES?

☐ YES ☐ NO

CIGARETTE/TOBACCO USE

_____

YEARS SMOKED

ATHLETIC ACTIVITIES IN WHICH YOU PARTICIPATE(PLEASE LIST AND INDICATE FREQUENCY)

_____

_____

_____

_____

_____

_____

_____

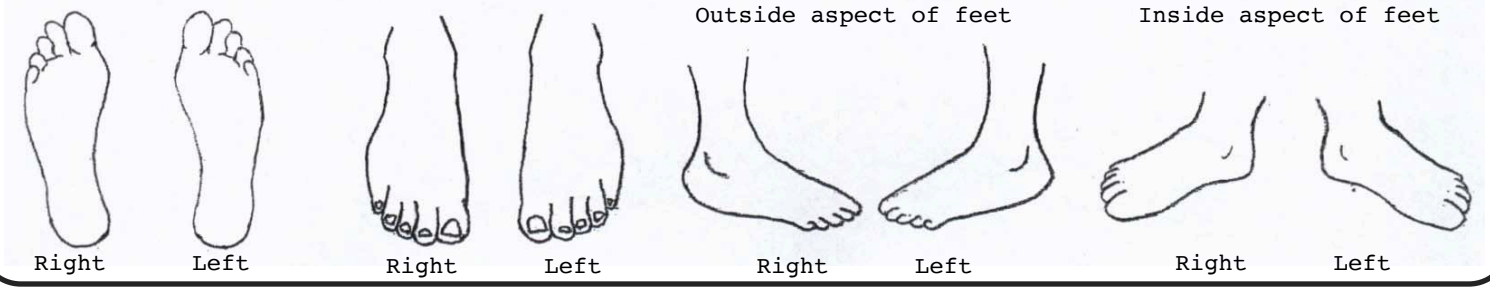
PLEASE INDICATE WHICH FOOT PROBLEMS YOU NOW HAVE OR HAVE HAD IN THE PAST

ACHILLES TENDONITIS	☐YES	☐NO
ANKLE SPRAINS	☐YES	☐NO
ATHLETE'S FOOT	☐YES	☐NO
BUNIONS	☐YES	☐NO
CORNS AND CALLUSES	☐YES	☐NO
FLAT FEET	☐YES	☐NO
FOOT OR LEG CRAMPS	☐YES	☐NO
FOOT ULCER	☐YES	☐NO
HEEL PAIN	☐YES	☐NO
INGROWN TOENAILS	☐YES	☐NO

LIMB LENGTH DIFFERENCE ☐YES ☐NO

NEUROMA	☐YES	☐NO
NUMBNESS IN FEET	☐YES	☐NO
PLANTAR WARTS	☐YES	☐NO
SWELLING IN ANKLES OR FEET	☐YES	☐NO
TIRED FEET	☐YES	☐NO

Please Circle Problematic Area



MEDICAL HISTORY

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU EVER HAVE HAD ANY OF THE FOLLOWING:

AIDS/HIV	☐YES	☐NO	EPILEPSY	☐YES	☐NO	RASH	☐YES	☐NO
ALLERGIES TO ANESTHETICS	☐YES	☐NO	EYE PROBLEMS	☐YES	☐NO	RESPIRATORY DISEASE	☐YES	☐NO
ALLERGIES TO MEDICINE OR DRUGS	☐YES	☐NO	FAINTING	☐YES	☐NO	RHEUMATIC FEVER	☐YES	☐NO
			FOOT OR LEG CRAMPS	☐YES	☐NO	SHORTNESS OF BREATH	☐YES	☐NO
ANEMIA	☐YES	☐NO	GOUT	☐YES	☐NO	SINUS PROBLEMS	☐YES	☐NO
ARTHRITIS	☐YES	☐NO	HEADACHES	☐YES	☐NO	SPECIAL DIET	☐YES	☐NO
ARTIFICIAL HEART VALVES OR JOINTS	☐YES	☐NO	HEART DISEASE	☐YES	☐NO	STROKE	☐YES	☐NO
ASTHMA	☐YES	☐NO	HEMOPHILIA	☐YES	☐NO	SWELLING IN ANKLES, FEET	☐YES	☐NO
BACK PROBLEMS	☐YES	☐NO	HEPATITIS	☐YES	☐NO	SWOLLEN NECK GLANDS	☐YES	☐NO
BLEEDING DISORDERS	☐YES	☐NO	HIGH BLOOD PRESSURE	☐YES	☐NO	TIRED FEET	☐YES	☐NO
CANCER	☐YES	☐NO	KIDNEY PROBLEMS	☐YES	☐NO	TUBERCULOSIS	☐YES	☐NO
CHEMICAL DEPENDANCY	☐YES	☐NO	LIVER DISEASE	☐YES	☐NO	ULCERS, FEET	☐YES	☐NO
CHEST PAIN	☐YES	☐NO	LOW BLOOD PRESSURE	☐YES	☐NO	ULCERS, STOMACH	☐YES	☐NO
CHRONIC DIARRHEA	☐YES	☐NO	NEUROPATHY	☐YES	☐NO	VARICOSE VEINS	☐YES	☐NO
CIRCULATORY PROBLEMS	☐YES	☐NO	PHLEBITIS	☐YES	☐NO	VENEREAL DISEASE	☐YES	☐NO
DIABETES	☐YES	☐NO	PSYCHIATRIC CARE	☐YES	☐NO	WEIGHT LOSS, UNEXPLAINED	☐YES	☐NO
EAR PROBLEMS	☐YES	☐NO	RADIATION TREATMENT	☐YES	☐NO			

SURGERIES YOU HAVE HAD _____

_____

HOSPITALIZATIONS OTHER THAN THE SURGERIES LISTED _____

_____

FAMILY PHYSICIAN: NAME _____ PHONE _____

OTHER PHYSICIAN(S): NAME _____ PHONE _____
(ex: heart and/or vascular)
NAME _____ PHONE _____

MEDICATIONS

INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDICATIONS AND VITAMINS:

_____

_____

PHARMACY NAME(S) _____

PHARMACY NUMBER(S) _____

DO YOU TAKE ORAL CONTRACEPTIVES? ☐YES ☐NO

ALLERGIES

- ☐ ADHESIVE/TAPE
- ANTICOAGULANT THERAPY
- ☐ ASPIRIN
- ☐ CODEINE
- ☐ DEMEROL
- ☐ IODINE
- ☐ LOCAL ANESTHESIA
- ☐ NOVOCAINE
- ☐ PENICILLIN
- ☐ SEAFOODS
- ☐ SULFA
- ☐ OTHER _____

TREATMENT CONSENT

I HEREBY CONSENT AND GIVE PERMISSION TO THE DOCTOR (AND THE DOCTOR'S ASSISTANTS OR DESIGNATED REPLACEMENT) TO ADMINISTER AND PERFORM SUCH PROCEDURES ON ME AS THE DOCTOR DEEMS NECESSARY

_____ _____
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

_____ _____
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT