BARRIE FOOT CLINIC - PATIENT INFORMATION

Name:_____ Date of Birth: D/ M/ Y/

Address:_____ City:_____ Postal Code:_____

Phone (home):_____ Phone (work/cell):_____

e-mail:_____ Doctor/NP: _____ City: _____

Occupation: Employer:

Referred by/How You Found Us:

Medical Insurance? ○ Yes ○ No Name of Company:

What is your main complaint:

1. How is your general health? ☐ GOOD ☐ FAIR ☐ POOR
2. Are you taking any medications at this time? ☐ YES ☐ NO

   If yes, please have a list of medications available.
3. Have you ever been to a chiropodist/podiatrist/foot specialist? ☐ YES ☐ NO
4. Have you ever had or been treated for any of the following? Please circle

☐ Diabetes	☐ Stomach ulcer	☐ Rheumatic fever	☐ Shortness of breath
☐ Heart trouble	☐ Gout	☐ Drug abuse	☐ High/low blood pressure
☐ Leg cramps	☐ Arthritis	☐ Cancer	☐ Difficulty in healing
☐ Stroke	☐ Kidney problems	☐ Anemia	☐ Epilepsy/blackouts/fainting
☐ Past surgery	☐ Skin Conditions	☐ Phlebitis or blood clot	☐ Liver problems/hepatitis
☐ Thyroid	☐ Autoimmune disorders	☐ Neurological disorders	☐ Respiratory conditions

5. Disability? Please specify: _____
6. Have you ever had or been treated for communicable diseases? Please circle

   ☐ HIV/AIDS ☐ HEPATITIS ☐ TB ☐ OTHER
7. Are you allergic to any of the following? Please circle

☐ Penicillin	☐ Novocain	☐ Aspirin	☐ Any antibiotic
☐ Tape	☐ Cortisone	☐ Codeine	☐ Latex

   Other medication allergies: _____
8. Are you subject to prolonged bleeding? ○ YES ○ NO
9. Is there any family history of diabetes? ○ YES ○ NO

I hereby authorize the Chiropodist in charge to perform treatment and/or any procedures necessary in the assessment of my foot condition. ** I also understand that no part of the cost for treatment offered by a Chiropodist is covered under O.H.I.P. The fee, however, may be covered under an Extended Health Care Plan.

Signature: _____ Date: _____