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: ______________________________