



NEW PATIENT FORM

WELCOME TO OUR OFFICE

Name: \_\_\_\_\_ AHC#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Hm Ph #: \_\_\_\_\_

Work Ph#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Email Address: \_\_\_\_\_

Are you interested in receiving our online newsletter? Yes  No

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Spouse/Closest Relative: \_\_\_\_\_ Phone #: \_\_\_\_\_

Your Physician's Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

How did you hear about the clinic? \_\_\_\_\_

Former Podiatrist: \_\_\_\_\_ Approximate date of last visit: \_\_\_\_\_

What is your present foot problem? \_\_\_\_\_

\_\_\_\_\_

**PLEASE ANSWER EACH QUESTION**

1. Are you in good health? Yes\_\_No\_\_
2. Are you or have you been under the care of a **Physician** during the past two years? If so what for? \_\_\_\_\_ Yes \_\_No\_\_
3. Are you subject to **prolonged bleeding** after a cut? Yes \_\_No\_\_
4. Are you a **slow healer** or do you **scar easily**? Yes \_\_No\_\_

Continue on Next Page

5. Do you have any drug **allergies** (i.e. Penicillin, Sulfa, Novocaine) or allergies to food (i.e. shellfish)? Yes \_\_No\_\_  
 Yes \_\_No\_\_
6. Have you ever had **cortisone** therapy? Yes \_\_No\_\_
7. Have you had any surgery in the past 10 years? Yes \_\_No\_\_
8. Have you had any **injuries or surgery** to your legs or feet? Yes \_\_No\_\_
9. Have you ever experienced any **unfavorable reaction** from any previous Podiatric treatment? Yes \_\_No\_\_
10. Do you have any **allergies**? If yes, what? \_\_\_\_\_
11. What **medications** are you presently taking? \_\_\_\_\_  
 \_\_\_\_\_

12. Have you ever been treated for any of the following?
- |                        |            |                          |            |
|------------------------|------------|--------------------------|------------|
| Diabetes Mellitus      | Yes __No__ | Asthma, Hay Fever        | Yes __No__ |
| Heart Problems         | Yes __No__ | Kidney Ailments          | Yes __No__ |
| High Blood Pressure    | Yes __No__ | Liver Ailments           | Yes __No__ |
| Circulation Problems   | Yes __No__ | Arthritis                | Yes __No__ |
| Rheumatic Fever        | Yes __No__ | Low Back Pain            | Yes __No__ |
| Anemia, Blood Disorder | Yes __No__ | Skin Problems            | Yes __No__ |
| Lung Problems          | Yes __No__ | Nervous System Disorders | Yes __No__ |
| Epilepsy               | Yes __No__ | Hepatitis                | Yes __No__ |

13. Is there any other information or history about your health which should be known?  
 \_\_\_\_\_  
 \_\_\_\_\_

I give my permission to administer treatment and to perform such procedures as may be necessary in the diagnosis and/or treatment of my foot condition.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

