ACHILLES
FOOT CLINIC

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__

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5. Do you have any drug **allergies** (i.e. Penicillin, Sulfa, Novocaine) Yes __No__
   or allergies to food (i.e. shellfish)? 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: _____

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