PICKERING footclinic

PATIENT REGISTRATION AND MEDICAL HISTORY

Please complete the following carefully so that we will have accurate and reliable records to provide you with the highest standard of care. ***Please note that services are not covered under OHIP.***

Today's Date: _____ / _____ / _____
dd mm yyyy

Title: (circle one) Dr. Mr. Mrs. Miss. Ms.
Name: _____Age:_____
Date of Birth:_____ Occupation:_____
Shoe Size:_____ Height:_____ Weight: *(lbs)*_____
Address: *(street)* _____
(city) _____ *(postal code)* _____
Home #:_____ Mobile #: _____
Business #: _____ Email Address: _____

Family Doctor Name: _____
Family Doctor
Address:_____
_____
Family Doctor #: _____

How did you hear about us? ☐ Google ☐ Foot Flyer ☐ Facebook ☐ Saw ad in building
☐ LifeLabs ☐ Referral_____ ☐ Other (*specify*)_____

What is the reason for your visit today?

☐ Nail Care ☐ Assessment ☐ Foot Pain ☐ Wart ☐ Ingrown Nail
☐ Foot Care ☐ Corn/Callous ☐ Custom Foot Orthotics ☐ Diabetic Foot Care
☐ Other (*specify*)_____

Have you ever been diagnosed with any of the following? Please check off all that apply.

☐ Arthritis / Osteoarthritis / Rheumatoid Arthritis
☐ Urinary / Digestive Problems
☐ Gout
☐ Cardiovascular disease
☐ Kidney Disease
☐ Thyroid (Hypothyroidism / Hyperthyroidism)
☐ High blood pressure
☐ High cholesterol
☐ Tension / Stress
☐ Fibromyalgia
☐ Liver disease
☐ Anxiety / Depression
☐ Hepatitis / HIV
☐ Cancer
☐ Asthma / Respiratory disease
☐ Seizures

Do you have Diabetes? ☐ No ☐ Yes → ☐ Type 1 or ☐ Type 2

If you have Diabetes, what are your average glucose levels? _____

What is your HbA1C? _____

Do you have any other medical conditions? ☐ No ☐ Yes *(please specify)*

_____

_____

_____

Are you taking any prescribed medications? ☐ No ☐ Yes

*(please list)*_____

_____

_____

Do you have any allergies? ☐ No ☐ Yes

(please list) _____

Have you had your feet checked before? ☐ No ☐ Yes - If yes, when? _____

OFFICE POLICY: Please give the office a minimum of 24hrs notice if an appointment needs to be changed or cancelled. Late and Missed appointments will result in a $25.00 fee. By signing below you accept this. ***Please note that services are not covered under OHIP***.

_____ _____

Signature Date