ACHILLES
FOOT CLINIC

WELCOME TO OUR OFFICE

Name: _____ AHC: _____

Address: _____

City:_____ Province:_____ Postal Code:_____

Hm Ph#:_____ Cell Ph #_____

Work Ph #:_____

Email Address:_____

Age:_____ Birth date:_____ Occupation:_____

Emergency Contact: _____ Ph#:_____

Your Physician's Name:_____ Ph#:_____

How did you hear about the clinic? Please circle which one applies: Radio 97.7 Radio 770 Herald Internet Sign Dr. Ref Patient Ref Yellow Pages Other:_____

Former Podiatrist: _____ Approximate date of last visit:_____

Insurance Company:_____

What is your present foot problem?_____

_____

PLEASE ANSWER EACH QUESTION

1. Are you in good health? Yes__No__

2. Are you or have been under the care of a Physician during the past two years? If so

What for?_____ Yes__No__

3. Are you subjected to prolonged bleeding after a cut? Yes__No__

4. Are you a slower healer or do you scar easily? Yes__No__

5. Do you have any drug and or food allergies (i.e. Penicillin, Sulfa, Novocaine) Yes__No__

If yes, what? _____

6. Have you ever had cortisone therapy? Yes__No__

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7. Have you had any injuries or surgery to your legs or feet? **Yes__No__**

8. Have you ever experienced any unfavorable reaction from any previous podiatric treatment? **Yes__No__**

9. What medications are you presently taking?_____

_____

_____

11. 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__**

12. 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/Guardian Signature:_____**Date:**_____