SIMARD FOOT & ANKLE CLINIC

New Patient Information Form

Patient Name: First : _____ Last: _____ Initial: ____
Birthdate (M / D / Y):_____ Age:_____ Gender: (F) ☐ (M) ☐
Address: _____ City: _____ Postal Code: _____
Home Phone: _____ Cell: _____ Work: _____ Email: _____
What is your preferred method of contact : ☐Home Phone ☐Work ☐Cell
Employer: _____ Occupation: _____
Emergency Contact: Name: _____ Phone: _____ Relationship: _____

Family Physician / NP: _____ Phone : _____

Extended Health Benefits: ☐ Yes ☐ No
If Yes, please indicate your Insurance Provider: _____
Are you covered by any of the following?
☐Veteran's Affair's Canada ☐Ontario Disability Support Program ☐Ontario Works
☐Non-Insured Health Benefits (First Nations/Inuit) ☐WSIB

Whom may we thank for referring you to our office: Name: _____
☐Television ☐Internet ☐Phone Book ☐Physician ☐Word of Mouth ☐Other _____

PODIATRIC HISTORY

	Yes	No		
Have you had any major foot or leg injuries?	☐	☐		
Do you get numbness in your feet or toes?	☐	☐		
Do you get tingling in your feet or toes?	☐	☐		
Do you get foot or leg cramps?	☐	☐		
Did your parents have foot problems?	☐	☐		
Do your feet perspire excessively?	☐	☐		
Are your feet excessively dry?	☐	☐		
Do your feet have a strong odour?	☐	☐		
Do you treat your own feet or cut your own callouses?	☐	☐		
Do you find your feet to be hot,cold or normal?	☐Hot	☐Cold	☐Normal	
Do you walk toe in, toe out or normal?	☐Toe in	☐Toe out	☐Straight	

Have you had foot care by another Chiropodist / Foot Specialist? ☐ Yes ☐ No
If yes, by whom? _____ When? _____
Have you had previous Foot x-rays? ☐ Yes ☐ No
If yes, where? _____ When? _____

Briefly describe your current foot problems: _____
_____
_____
_____

Shoe Size: _____ What **footwear** do you most commonly wear? _____

MEDICAL HISTORY

MAJOR DISEASE

☐Heart ☐Arrhythmia ☐Heart Attack
☐Diabetes ☐Stroke ☐Heart Murmur
☐High Blood Pressure ☐Chest pain ☐Mitral Valve Prolapse

RESPIRATORY

☐Asthma
☐Bronchitis
☐Frequent Colds

ARTHRITIS

☐Osteoarthritis
☐Rheumatoid
☐Gout

GASTROINTESTINAL

☐Acid Reflux
☐Bowel Disorders
☐Crones

VASCULAR

☐Anemia ☐Bleeding Disorders ☐Blood Clots
☐Sickle Cell ☐Swelling Phlebitis ☐Vein Problems
☐Poor Circulation ☐Leg Ulcerations ☐Spider Veins
☐Transfusions ☐Night Cramps ☐Varicose Veins
☐Leg Pain When Walking

MISC

☐Diabetes ☐Bladder Problems ☐Cancer History
☐Muscle Disease ☐Prostate Problems ☐Hepatitis A, B, C
☐Kidney Problems ☐Skin Conditions ☐Thyroid Disease

PSYCHOLOGICAL

☐Anxiety ☐Depression ☐Alcohol Dependence
☐Drug Dependence ☐Psychiatric Conditions

☐Other Illnesses_____

HAVE YOU EXPERIENCED ADVERSE SIDE EFFECTS FROM ANY OF THE FOLLOWING?

☐Aspirin/ASA ☐Neomycin/Polysporin ☐Steroids
☐Erythromycin ☐Novocain/Freezing ☐Sulfa Drugs
☐Latex ☐Penicillin ☐Tape allergy
☐Codeine ☐Iodine/Shellfish ☐Other: _____

Have you ever tested **positive** for Hepatitis or HIV? ☐Yes ☐No
Are you currently pregnant? ☐Yes ☐No
Do you smoke tobacco? ☐Yes ☐No If yes, #/day _____
Alcohol consumption: ☐None ☐1-2 week ☐1-2 day ☐more than 2 day

Date of last doctor's visit: _____ Height: _____ Weight: _____

PLEASE LIST ALL CURRENT MEDICATIONS: (If multiple medications please bring list from Pharmacy)

_____

_____

Which Pharmacy do you use? _____