

# SIMARD FOOT & ANKLE CLINIC

## Patient Information Form

Today's Date:		
Reason you require this Chiropody consultation:		
<b>Patient Name:</b> First:	Last:	Middle Initial:
Birthdate (M / D / Y):	Age:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unspecified <input type="checkbox"/> Other
Address:	City:	Postal Code:
Cell Number:	Landline:	Work Phone:
What is your preferred phone number to be reached? <input type="checkbox"/> Cell Phone <input type="checkbox"/> Landline <input type="checkbox"/> Work Phone		
Email for correspondence with Simard Foot & Ankle Clinic - (Enter email):		
<b>Emergency Contact:</b> Name (First,Last) :	Phone:	Relationship:
Family Dr /NP Name:	Family Dr /NP Location:	
Employer:	Occupation:	
<b>Extended Health Benefits:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
1. Primary Insurance Company:		
If Greenshield, enter your GSC number:		
2. Secondary Insurance Company:		
<b>Are you covered by any of the following?</b>		
<input type="checkbox"/> Veteran's Affairs Canada <input type="checkbox"/> Ontario Disability Support Program <input type="checkbox"/> Ontario Works		
<input type="checkbox"/> Non-Insured Health Benefits (First Nations/Inuit) <input type="checkbox"/> WSIB		
<b>How did you hear about us?</b> <input type="checkbox"/> Internet <input type="checkbox"/> Social Media <input type="checkbox"/> Phone Book <input type="checkbox"/> Clinic Signage <input type="checkbox"/> Word of Mouth		
<input type="checkbox"/> Physician <input type="checkbox"/> ER Doctor <input type="checkbox"/> Walk-In Clinic		
*If you were referred to our office, please enter individual's name:		
<b>PODIATRIC HISTORY</b>		
When did your current issue start?	Location of your current issue:	
What is the typical pain level of your current issue: (0 = no pain) 0 1 2 3 4 5 6 7 8 9 10 (10 = extreme pain)		
List any treatments/therapies that you have already tried to resolve issue:		
Have you had any major foot or leg injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever had foot or ankle surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, by whom?	Date:
Have you ever received care from a foot health provider?		
<input type="checkbox"/> No, I have never received care for my feet		
<input type="checkbox"/> Yes, currently I see someone for my feet		
<input type="checkbox"/> Yes, but I am no longer seeing them		
If yes, name of provider:		Date of last visit:
Have you had previous Foot x-rays? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, enter name of imaging facility:		Approximate date of Xrays:
Shoe Size:	What type of <b>footwear</b> do you most commonly wear?	

## MEDICAL HISTORY

### MAJOR DISEASE

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart               | <input type="checkbox"/> Arrhythmia     | <input type="checkbox"/> Heart Attack          |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Stroke         | <input type="checkbox"/> Heart Murmur          |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chest pain     | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Muscle Disease      | <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Cancer History        |

### RESPIRATORY

- Asthma
- Bronchitis
- Frequent Colds

### ARTHRITIS

- Osteoarthritis
- Rheumatoid
- Gout

### GASTROINTESTINAL

- Acid Reflux
- Bowel Disorders
- Crohns

### VASCULAR

- Anemia
- Sickle Cell
- Poor Circulation
- Transfusions
- Leg Pain When Walking

- Bleeding Disorders
- Swelling Phlebitis
- Leg Ulcerations
- Night Cramps

- Blood Clots
- Vein Problems
- Spider Veins
- Varicose Veins

### PSYCHOLOGICAL

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Depression             | <input type="checkbox"/> Alcohol Dependence |
| <input type="checkbox"/> Drug Dependence | <input type="checkbox"/> Psychiatric Conditions |   |

### OTHER ILLNESSES

Any other illnesses not listed above:

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

- |                                       |  |                                       |
|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Aspirin/ASA  | <input type="checkbox"/> Neomycin/Polysporin | <input type="checkbox"/> Steroids     |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Novocain/Freezing   | <input type="checkbox"/> Sulfa Drugs  |
| <input type="checkbox"/> Latex        | <input type="checkbox"/> Penicillin          | <input type="checkbox"/> Tape allergy |
| <input type="checkbox"/> Codeine      | <input type="checkbox"/> Iodine/Shellfish    | <input type="checkbox"/> 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

Height:                      Weight:

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

Which Pharmacy do you use?