SIMARD FOOT & ANKLE CLINIC

Patient Information Form

Today's Date:

Reason you require this Chiropody consultation:

Patient Name: First: Last: Middle Initial:

Birthdate (M / D / Y): Age: Gender: ☐ Female ☐ Male ☐ Unspecified ☐ Other

Address: City: Postal Code:

Cell Number: Landline: Work Phone:

What is your preferred phone number to be reached? ☐Cell Phone ☐Landline ☐Work Phone

Email for correspondence with Simard Foot & Ankle Clinic - (Enter email):

Emergency Contact: Name (First,Last) : Phone: Relationship:

Family Dr /NP Name: Family Dr /NP Location:

Employer: Occupation:

Extended Health Benefits: ☐ Yes ☐ No

1. Primary Insurance Company:

If Greenshield, enter your GSC number:

2. Secondary Insurance Company:

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

How did you hear about us? ☐Internet ☐Social Media ☐ Phone Book ☐ Clinic Signage ☐Word of Mouth ☐Physician ☐ER Doctor ☐Walk-In Clinic

*If you were referred to our office, please enter individual's name:

PODIATRIC HISTORY

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? ☐ Yes ☐ No

Have you ever had foot or ankle surgery? ☐ Yes ☐ No - If yes, by whom? Date:

Have you ever received care from a foot health provider?

☐ No, I have never received care for my feet

☐ Yes, currently I see someone for my feet

☐ Yes, but I am no longer seeing them

If yes, name of provider: Date of last visit:

Have you had previous Foot x-rays? ☐ Yes ☐ No

If yes, enter name of imaging facility: Approximate date of Xrays:

Shoe Size: What type of **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
☐Muscle Disease ☐Skin Condition ☐Cancer History

RESPIRATORY

☐Asthma
☐Bronchitis
☐Frequent Colds

ARTHRITIS

☐Osteoarthritis
☐Rheumatoid
☐Gout

GASTROINTESTINAL

☐Acid Reflux
☐Bowel Disorders
☐Crohn's Disease

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

PSYCHOLOGICAL

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

OTHER ILLNESSES

Any other illnesses not listed above:

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

Height: Weight:

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

Which Pharmacy do you use?