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Name: Mr.
Ms. _____
Mrs.
Miss

Date of Birth: Day _____Month _____Year _____

Street # Street Name Unit #

City Province Postal Code

Telephone: Home: _____Business: _____

Cell: _____

Email Address: _____

Who referred you to this office? Patient: _____

Other: _____

Doctor: _____

If it was your Doctor who referred you please fill out the section below:

Family Physician: _____
Title First Name Last Name

(___)_____ (___)_____
Physician telephone # Physician Fax #

How is your overall health? GOOD FAIR POOR

Are you currently taking any medications? YES NO

Please list medications:_____

_____

Do you have or have you had any of the following?	YES	NO
Heart conditions (e.g. rheumatic fever, pacemaker)	☐	☐
Diabetes	☐	☐
Arthritis (e.g. rheumatoid, osteoarthritis, gout)	☐	☐
Respiratory conditions (e.g. asthma, shortness of breath)	☐	☐
Abnormal blood pressure	☐	☐
Gastrointestinal conditions (e.g. stomach ulcer)	☐	☐
Tuberculosis	☐	☐
Liver/kidney disease	☐	☐
Circulatory disorders (e.g. raynauds, blood clots, leg cramps)	☐	☐
Subject to prolonged bleeding	☐	☐
Communicable disease (e.g. hepatitis, HIV)	☐	☐
Blackouts (e.g. epilepsy)	☐	☐
If applicable, may you be pregnant?	☐	☐
Difficulty in healing	☐	☐

Are you allergic to any of the following?

	YES	NO		YES	NO
Any antibiotic	☐	☐	Latex	☐	☐
Novocaine	☐	☐	Tape	☐	☐

If other medications, please list:_____

What is the nature of the problems you would like the chiropodist to take care of?

Written Consent

I hereby give my permission to the chiropodist at the North York Foot Clinic to examine and treat my feet by medical, orthopedic, or minor surgical methods. All information will be kept confidential and will not be released to any person or 3rd party without your written consent.

Date: _____Signature: _____
Month / Day / Year

Name of parent/guardian (please print): _____

Signature of parent/guardian (if patient is under the age of majority):

_____