PATIENT INFORMATION

(Please Print)

Name_____ **Male** ☐ **Female** ☐

Address_____ **Email:**_____

Street **Apt. #**

City_____ **Postal Code**_____ **Occupation** _____

Family Physician:_____

Date of Birth____/____/____

m **d** **yr**

Telephone Number (H)_____**(W)** _____**(Cell)**_____

How did you hear about our office? ☐ **Yellow Pages** ☐ **Website** ☐ **Friend** ☐**Other**_____

Referred by: ☐ **Doctor** ☐ **Existing Patient** ☐ **Self**

Emergency Contact:_____**Relationship:**_____ **Telephone Number:**_____

PLEASE DESCRIBE your foot problem: _____

Have you had any of the following illnesses?

	Yes	No
1. Heart problems	☐	☐
2. Stroke	☐	☐
3. Rheumatoid Arthritis	☐	☐
4. Polio	☐	☐
5. Gout	☐	☐
6. Psoriasis	☐	☐
7. Diabetes	☐	☐
8. History of ulcers or gangrene in the leg/foot/toes	☐	☐
9. Hepatitis	☐	☐
10. Sexually transmitted disease	☐	☐

State if you have any medical conditions not listed above:_____

Have you ever had any foot surgery or foot problems? ☐ ☐

If yes, when and where:_____

Are you presently taking any medications? ☐ ☐

If yes, please list:_____

Are you allergic to any medication? ☐ ☐

If yes please list_____

Are you allergic or have any known allergies to local anesthetic? ☐ ☐

Have you ever had local anesthetic? If yes, please list_____

Have you ever fainted? ☐ ☐

If required I consent to the administration of a local anesthetic. ☐ ☐

What kind of shoes do you wear? ☐**Oxfords** ☐ **Slip-On** ☐**Runners** ☐**Walking** ☐**Work Boot** ☐**Dress Shoes**

		Yes	No
Do you have coverage through:	**WCB**	☐	☐
	DVA	☐	☐
	First Nations	☐	☐
	Community and Social Services	☐	☐

I consent to the use of my email for Foot Works' monthly educational Enews which provides valuable information such as foot care tips, service updates and upcoming events. Yes ☐ No ☐

I hereby state that the above information is true to the best of my knowledge and I understand there is a fee for service practice, which is NOT covered by O.H.I.P.

Signature_____ Date_____