THE FOOT CLINIC - CHIROPODY HISTORY
4915 BATHURST STREET, SUITE 224, TORONTO, ONTARIO M2R 1X9 | (416) 638-FEET (3338)

FILE #_____

PATIENT PLEASE COMPLETE

LAST NAME	FIRST NAME	MIDDLE NAME
ADDRESS		SUITE
CITY	PROVINCE	POSTAL CODE

HOME PHONE	WORK PHONE	EXT.	CELLPHONE

HEIGHT	WEIGHT	SHOE SIZE	EMAIL ADDRESS
cm	lbs	HOW DID YOU HEAR ABOUT US?	
ft/in	kgs	FAMILY DOCTOR	BIRTH DATE (MM/DD/YEAR)

WHAT IS THE NATURE OF YOUR FOOT PROBLEMS? (CHECK ALL THAT APPLY)

☐ CORNS ☐ R ☐ L ☐ INGROWN TOE NAIL ☐ R ☐ L ☐ PAINFUL FEET ☐ R ☐ L ☐ INFECTION ☐ R ☐ L

☐ CALLUS ☐ R ☐ L ☐ THICKENED TOE NAIL ☐ R ☐ L ☐ WARTS ☐ R ☐ L ☐ ATHLETE'S FOOT ☐ R ☐ L

OTHER _____

MEDICAL CONDITIONS

☐ DIABETES INSULIN PILLS DIET
WHEN DIAGNOSED?
_____

☐ HIGH BLOOD PRESSURE
WHEN DIAGNOSED?
_____

☐ HEART PROBLEMS
☐ ANGINA
☐ HEART DISEASE
☐ STROKE WHEN? _____
☐ HEART ATTACK WHEN? _____
☐ OSTEOARTHRITIS
☐ SURGERY
WHAT? WHEN?
1) _____
2) _____
3) _____

☐ FRACTURES
WHERE? WHEN?
R _____
L _____

☐ COMMUNICABLE DISEASES
1) _____
2) _____

MEDICAL CONDITIONS CONTINUED

☐ BLOOD DISORDERS

☐ NEUROPATHY ☐ R ☐ L
☐ HYPERSENSITIVITY ☐ R ☐ L
☐ NEUROMUSCULAR DISORDER

☐ CIRCULATORY STATUE
☐ PERIPHERAL VASCULAR DISEASE
☐ SMOKER
HOW MUCH
HOW LONG

☐ VARICOSE VEINS ☐ R ☐ L
☐ ARTERIAL INSUFFICIENCY ☐ R ☐ L
☐ VENOUS INSUFFICIENCY ☐ R ☐ L
☐ NIGHT CRAMPS ☐ R ☐ L
☐ CLAUDICATION ☐ R ☐ L
☐ TROPHIC CHANGES ☐ R ☐ L
☐ GOOD CIRCULATION ☐ R ☐ L
☐ OTHER

LEVEL OF CARE
☐ PALLIATION
☐ ORTHOTIC MANAGEMENT

PRESENT FOOTWEAR
_____

CURRENT MEDICATIONS

NAME/DOSE/HOW OFTEN?
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

DRUG ALLERGIES
1) _____
2) _____
3) _____

RUNNER
HOW MUCH? _____
HOW OFTEN? _____

CURRENT ACTIVITIES
_____
_____

I CONSENT TO FOOT CARE TREATEMENT AT THE FOOT CLINIC. PATIENT/GUARDIAN SIGNATURE

_____

DATE (MM/DD/YEAR)
_____

SUBMIT BY EMAIL

PRINT