ROBERT CHELIN, D.P.M.
STEPHEN PARKER, D.Ch.

DURHAM FAMILY FOOT CARE CLINIC & WELLNESS CENTRE

FOR PATIENT PROTECTION, ALL INSTRUMENTS ARE COMPLETELY STERILIZED BEFORE EACH TREATMENT ACCORDING TO REGULATIONS.

We are pleased you have confided in us for your foot care. The staff wishes to welcome you to our office. We take pride in our professional capabilities and will attempt to accommodate you in every way possible. We accept new patients without Doctor referral. Adult foot problems begin in childhood. Please have your children's, grandchildren's feet examined!

Please answer the following questions **fully** to help us become better acquainted. If you need assistance do not hesitate to ask the receptionist.

Name ______________________________ Date ______________

Parent or Guardian's name if patient is under age 18 ______________________________

Address ______________________________ Apt. # __________

City/Town ______________________________ Postal Code ☐☐☐ - ☐☐☐

Phone Number (Home) ( ) ______________ (Work) ( ) ______________ Ext. __________

Health Card Number ☐☐☐☐☐☐☐☐☐☐ ☐☐ Version Code Expiry Date ______________

Date of Birth DAY ☐☐ MONTH ☐☐ YEAR ☐☐

Shoe Size ______________ Weight ______________ Age ______________

Occupation ______________________________

Employer ______________________________

Are you or your spouse covered under any additional type of medical insurance that covers prescriptions, eyeglasses or dental eg: Great West Life, Blue Cross, Aetna, etc.

☐ Yes ☐ No ______________________________

How did you hear about our office, or who referred you? ______________________________

Name of person who referred you ______________________________

Are you allergic to medications or materials? ☐ Yes ☐ No

If yes specify ______________________________

Is there a personal or family history of diabetes? ☐ No ☐ Self ☐ Mother ☐ Father

If self: ☐ Pills ☐ Insulin Injections

CONTINUED ON OTHER SIDE...

Are you pregnant? ☐ Yes ☐ No ☐ Maybe

• If yes or maybe please inform receptionist!

Do you wear high heels? ☐ Occasionally ☐ For Work ☐ Daily ☐ Never

At present, do you take any medications regularly, including birth control?

☐ Yes ☐ No (Please list) ____________________

____

Have you tested HIV POSITIVE? ☐ Yes ☐ No ☐ Have not been tested

Do you have any diseases or medical conditions? ☐ Yes ☐ No

What are they ____________________

Are you subject to prolonged bleeding: ☐ Yes ☐ No / Are you taking blood thinners? ☐ Yes ☐ No

Do you have problems healing: ☐ Yes ☐ No / Are you prone to infection? ☐ Yes ☐ No

Have you been treated or had surgery for any serious medical problems, ie. Heart, Kidney, etc?

(Please list) ____________________

Have you ever fainted in a doctor's office: ☐ Yes ☐ No / Or when giving blood ☐ Yes ☐ No

Name of family doctor ____________________ Last visit ____________

Address or street ____________________ Phone (   ) ____________

Have you ever had your feet examined? ☐ Yes ☐ No By whom: ____________

Name of former podiatrist ____________________

Have you ever worn orthotics (shoe inserts)? ☐ Yes ☐ No Who made them? ____________

What is your foot problem? ____________________

____

____________________ as opposed to an M.D. (Medical Doctor) consequently there is a fee for examination, x-rays (if necessary) and/or treatment. You are responsible for fees the day of your visit!

____________________ ____________________

Date Signature

Occasionally, we must change or confirm a future appointment. Who can we call if we cannot reach you?

(neighbour, relative, friend, etc.) Phone Number (   ) ____________________

Name ____________________ Relationship ____________________