ASSOCIATE FOOT SPECIALISTS

DISEASES, INJURIES & SURGERY OF THE FOOT

NO REFERRAL NECESSARY · WE MAKE CUSTOM ORTHOTICS

www.associatefootspecialists.com

The doctors and staff at Associate Foot Specialists Clinic wish to welcome you to our office. Please answer these questions to help us become better informed. If you need help, please do not hesitate to ask.

SURNAME: _____ GIVEN NAME: _____ DATE: _____

ADDRESS: _____ _____ (CITY) _____ (POSTAL CODE)

BIRTHDATE: _____ (Day/Month/Year) AGE: _____ SEX: _____ MARITAL STATUS: ☐S ☐M ☐W ☐D

OCCUPATION: _____ EMPLOYED BY: _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____ CELL PHONE: ( ) _____

ALBERTA HEALTH CARE NO: _____ E-MAIL: _____

PARTY RESPONSIBLE FOR PAYMENT OF THOSE SERVICES NOT COVERED BY ALBERTA HEALTH CARE:

_____

HAVE YOU SEEN A PODIATRIST IN THE LAST YEAR? ☐ YES ☐ NO

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

WHO MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

FAMILY PHYSICIAN: Dr. _____ (First) (Last) LAST PHYSICAL EXAM: _____

WHAT IS YOUR PRESENT FOOT PROBLEM? _____

_____

DOES PATIENT HAVE A HISTORY OF:

YES	NO	
_____	_____	DIABETES (IF YES, PLEASE FILL OUT INFORMATION ON BACK)
_____	_____	POOR CIRCULATION
_____	_____	HIGH BLOOD PRESSURE
_____	_____	HEART DISEASE
_____	_____	ANEMIA
_____	_____	BLEEDING ABNORMALITIES
_____	_____	KIDNEY PROBLEMS
_____	_____	HEPATITIS / CIRRHOSIS
_____	_____	ARTHRITIS
_____	_____	BACK PROBLEMS
_____	_____	GOUT
_____	_____	LUNG PROBLEMS
_____	_____	ASTHMA
_____	_____	HAY FEVER
_____	_____	**DO YOU SMOKE?**

IS PATIENT ALLERGIC TO:

YES	NO	
_____	_____	PENICILLIN
_____	_____	ASPIRIN
_____	_____	CODEINE
_____	_____	ADHESIVE TAPE
_____	_____	LOCAL ANESTHETIC
_____	_____	IODINE
_____	_____	SULFA
_____	_____	OTHER (PLEASE LIST)

WHAT MEDICATIONS ARE YOU TAKING? _____

_____

_____

DO YOU TAKE BLOOD THINNERS? ☐ YES ☐ NO

LIST PREVIOUS SURGERY OR SERIOUS ILLNESS: _____

_____

_____

DIABETIC PATIENT HISTORY

Please answer all of the following questions.

1) How long have you had diabetes? _____

2) Are you under the regular care of a physician for your diabetes? _____

3) Name of physician treating your diabetes: _____

4) Approximate date of last visit to your physician: _____

5) Please list current medications used to treat your diabetes: _____

_____

_____

6) If you use Insulin please list type, dosage and frequency: _____

_____

_____

7) Do you self-monitor your blood glucose? Yes / No How often? _____

8) Have you been hospitalized for any complications from diabetes? _____

If so, please state date(s) and reason for hospitalization: _____

_____

_____

_____

_____

_____

9) Do you consider your diabetes well controlled? _____

10) Have you previously been educated in diabetic foot care? _____

Thank You

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