Clinique Podiatrique NDG
Podiatry Clinic

MEMBRE DE
ORDRE DES PODIATRES DU QUÉBEC
Mes pieds. Ma santé. Mon podiatre.

REGISTRATION AND HISTORY FORM

All information will remain confidential and is required by the Quebec Podiatric law

PATIENT INFORMATION		Date: _____ /_____ /_____
Last Name (maiden):	First Name:	
Address:		
City:	Postal Code:	
Home Phone:	Work Phone:	
Cellular:	E-mail:	
I authorize the Podiatry Clinic to contact me by e-mail: Yes ☐ No ☐		
Date of Birth: Year_____ /Month_____ /Day_____	Age:	Sex: Male ☐ Female ☐
Height:	Weight:	Shoe size:
Medicare card number: (not used in our office)		Exp:
Occupation:		
In case of emergency, contact: Name:		
Relationship:	Phone Number:	
If you are under 18 of age, write the name of parent(s) or guardian(s):		
How did you hear about our clinic? _____		
PODIATRIC HISTORY		
Reason for today's consultation: _____		
Please describe your pain or problem:		
Duration:	Frequency:	
Localization and during which activity (standing, walking, bedtime, after activity):		
Have you ever been to a Podiatrist before? Yes ☐ No ☐ If yes, please list below:		
Name:	Last visit:	
Have you had podiatry treatments such as: Surgery? ☐ Orthotics? ☐ Warts? ☐ Heel pain? ☐		
Other ☐ _____		
OTHER INFORMATION		
Do you have insurance? Yes ☐ No ☐ If yes, Name: _____		
Family Physician:		
Phone:	Date of last visit:	
Are you currently under any other doctor's care for any reason? Yes ☐ No ☐		
If yes, please explain:		

Write your Current Medication or any you took in the last 6 months? (if you have a list, we can make a copy)_____

_____

_____

Do you take any:

Natural or homeopathic products? Which? _____ Yes No

_____

Hormones? _____ Yes No

Birth control pills? _____ Yes No

Are you pregnant? ——————————————— Yes No

Are you breastfeeding? ——————————————— Yes No

Are you diabetic? ——————————————— Yes No

If, yes what was your last blood sugar? _____

Are you suffering or ever suffered from:

Heart disease (murmur, stroke, angina, valvular problems)?—— Yes No

Blood problems (circle if yes)? ——————————— Yes No

Haemophilia Anemia

Prolonged bleeding Transfusions

Other, which? _____

Stomach ulcer? ——————————————— Yes No

Tuberculosis or lung problems? ——————————— Yes No

Digestive problems? ——————————————— Yes No

Which: _____

Liver diseases (hepatitis A, B, C, cirrhosis)? ————————- Yes No

Kidney problems? ——————————————— Yes No

Venereal diseases? ——————————————— Yes No

Skin problems? Which ? _____ Yes No

Thyroid problems? ——————————————— Yes No

Do you urinate often? ——————————————— Yes No

Rheumatic fever? ——————————————— Yes No

Eye problems (glaucoma, macular degeneration, cataracts)? Yes No

Arthritis? Which one? _____ Yes No

Osteoporosis? ——————————————— Yes No

Epilepsy? ——————————————— Yes No

Mental illness? ——————————————— Yes No

Do you have:

Dizzy/fainting spells ——————————————— Yes No

Asthma ——————————————— Yes No

Frequent headaches ——————————————— Yes No

Allergies (circle): Yes No

Latex Codeine Iodine Sulfa Aspirin

Local anesthesia Penicillin Other antibiotics Sea food

Other_____

Do you have symptoms of AIDS?——————————— Yes No

Are you an AIDS virus carrier? ——————————— Yes No

Have you ever had cancer? If yes, which? _____ Yes No

Any complications due to cancer treatments? Which ? _____ Yes No

_____

Have you ever had radiotherapy and/or chemotherapy? ——— Yes No

Do you use recreational drugs? Which? _____ Yes No

Your last blood pressure? High Low Normal

Have you recently gained or lost weight? Which?_____ Yes No

How many pounds/kilograms? _____

Nervous diseases? ——————————————— Yes No

Do you have artificial joints (knee, hip, etc.)? _____ Yes No

Have you ever had any surgeries or been hospitalized? _____ Yes No

_____

Other pathologies present (circle):

Phlebitis Polio Gout Psoriasis Vascular problems

Varicose veins

Other_____

Do you drink alcohol? No/ A little In moderation A lot

Glasses per week _____

Have you ever had injuries (fractures, sprains, etc.)?_____ Yes No

Which _____

Do you smoke? How many cigarettes per day? _____ Yes No

Minutes of physical activity per week: _____

Jogging _____ Weightlifting _____ Soccer _____

Yoga _____ Tennis _____ Hockey _____

Other _____

AGREEMENT AND CANCELLATION POLICY

You must advise us at least 24 hours in advance for any changes for a scheduled appointment. If you fail to do so, you will be charged a 45$ fee. I declare that the information above is accurate and complete. Additionally, I authorize my podiatrist to transmit and disclose my medical information to my insurance for reimbursement purposes and/or my physician, if necessary. I additionally agree to the cancellation policy.

Signature: _____ Date: _____

If the patient is a minor, please write the name of the guardian: _____