CHIROPODY PATIENT HISTORY

ROSS TEEPLE D.CH Chiropodist

NAME: _____ DATE OF BIRTH: MM____ DD____ YR_____
Preferred Name:_____ Email:_____
Home Phone #_____ ADDRESS: _____
Work / Cell #_____ CITY _____POSTAL CODE_____
Contact me: Phone_____ or Email_____ FAMILY PHYSICIAN:_____
OCCUPATION_____ EMERGENCY CONTACT: _____
REFERRED BY_____ PHONE NUMBER: _____
SHOE SIZE_____ PRIVATE INSURANCE CO._____

HISTORY OF FOOT PROBLEM

What is your present foot complaint?_____
_____
What have you done about it? (eg. Past treatment) _____
_____
Does this affect your walking or normal function? _____ How much? _____
Have you ever had any major foot or leg injuries?_____
Have you ever had any foot or leg surgery? _____
Have you ever had any infection or ulceration on your feet? _____
Do or did your parents ever have any foot problems? _____
Do you ever experience numbness or tingling in your feet? _____
Do you treat your own feet or cut your own calluses or toenails? _____

MEDICAL INFORMATION

Are you in good general health? _____
Are you very active? (running, sports, etc.) _____
Have you ever had severe chest pains or shortness of breath? _____
Are you subject to prolonged bleeding? _____
Have you ever fainted or passed out in a doctor's office? _____
Do you have a family history of diabetes? _____
Do you smoke? _____ Are you currently pregnant? _____
Have you ever had any major operations or hospitalizations? _____

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

Diabetes	Heart Problems	Epilepsy	Respiratory (i.e. Asthma)
Arthritis	Stroke	Depression	Stomach / Intestinal
Gout	High Blood Pressure	Cancer	Transplant
Kidney Problems	Circulation Problems	H.I.V. / Hepatitis	Neuromuscular i.e.
Liver Problems	Rheumatic/Scarlet Fever	Skin Conditions	(polio, Spina Bifida, C.P.)

Other:_____

ARE YOU ALLERGIC TO:
Drugs / Anesthetics _____ Tapes / Adhesives _____ Food / Environment _____

WHAT MEDICATIONS ARE YOU TAKING?_____
_____
_____

I HEREBY GIVE PERMISSION TO THE CHIROPODIST TO ADMINISTER SUCH MINOR OPERATIVE PROCEDURES AS MAY BE DEEMED NECESSARY IN THE CHIROPODIAL DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION.

DATE: _____ SIGNATURE: _____