

MEDICAL INFORMATION

	YES	NO
Are you in good health ?		
Have you been under a doctors care in the past two years? FOR WHAT ?		
Did anyone in your family (mother, father, grandparents) have foot problems similar to yours?		
Do your feet and/or legs cramp, fatigue, or strain easily?		
Have you had a history of low back pain?		
Do your ankles turn or sprain easily?		
Are the back or bottom of your HEELS painful?		
Are you regularly tired or exhausted?		
Do you spend more than 30% of your time on your feet?		
Do you limit your activities because your feet hurt?		
Do you smoke (HOW MUCH _____ / DAY), or drink alcoholic beverages (HOW MUCH _____)		
Do your feet or heels hurt in the morning?		
Are you subject to prolonged bleeding?		
Is there a family history of DIABETES, or ARTHRITIS (CIRCLE ONES THAT APPLY)		
Have you had any serious illnesses or operations? LIST:		
Have you ever fainted in a doctors office		
FEMALES : Are you PREGNANT?		
Have you ever tested positive for HEPATITIS		
Have you ever tested positive for HIV		
Do you take aspirin (ASA), coumadin, or other blood thinners (please circle ones that apply) OTHER MEDICATIONS:		

HAVE YOU EVER BEEN TREATED FOR **ANY** OF THE FOLLOWING?

High blood pressure	Diabetes	Stomach ulcers	Cancer	Liver problems
Shortness of breath	Arthritis	Rheumatic fever	Anemia	OTHER:
Difficulty in healing	Gout	Tuberculosis	Epilepsy	
Heart problems	Hepatitis	Kidney problems	Phlebitis	

HAVE YOU EXPERIENCED EFFECTS FROM **ANY** OF THE FOLLOWING?

Novocaine / 'Freezing'	Tape Allergy	Latex Allergy	Neomycin / Polysporin	Steroids
Penicillin	Sulfa drugs	Erythromycin	Aspirin / ASA	OTHER:

I hereby give my permission to Podiatry Associates to Examine and Treat my Feet. I acknowledge that a Podiatrist may charge fees for services NOT reimbursed by, and/or in addition to, the OHIP schedule of benefits.

DATE _____ SIGNATURE _____

**WE APPRECIATE YOUR COOPERATION
THANK YOU!
WE WILL BE WITH YOU IN A MOMENT**