OttawaFootPractice

Doctors of Podiatric Medicine

Welcome to Ottawa Foot Practice. Please complete the following confidential questionnaire to help us better serve your needs. We focus on providing our patients with a positive learning and healing experience. We welcome feedback and suggestions to improve.

Office Info. Only

☐Entered # ________ ☐ X-ray ☐Scan Date: D/_____M/_____Y/ _____

☐ I (+) ☐ I (–) ☐ I (0)

☐Dr. ☐ Mr. ☐Mrs. ☐Ms.

(First) ____ (Last) ___________________________________

I prefer to be called by my ☐ first name ☐ last name ☐ ____

Date of Birth: D/_____ M/_____ Y/ _______ Age _____ ☐M ☐ F

E-mail: ____

Address: ____

Unit or Apt. Number, Street Number & Street Name

____

City/Town Prov. Postal Code

Phone H: (613) _________________ W: (613) ________________ C: (613) _____________________

Parent name (if under18 year-old), guardian name or primary care name and phone number:

____(613) _________________________

Emergency Contact Name and phone number: ☐ same as above

____ (613) _________________________

How did you select OttawaFootPractice or hear about us? ______________________________________

____

I prefer to be contacted by ☐ phone ☐ e-mail ☐ I want to receive your quarterly E-Newsletter

*** To protect our patients, all instruments are cleaned, sealed and autoclaved in our hospital grade sterilization center before each treatment.

If you would like your family doctor to receive a report of your consultation this information <u>must be completely correctly</u>.

Name & phone number of your Family Doctor: _________________________________PH (613) _____________

Address of Clinic: ____Fax (613)_____________

Last Visit was approximatively on: D/________ M/________ Y/ __________

Shoe Size: __________ Foot Width: ☐Narrow ☐Medium ☐Wide Weight: ____ ☐ Kg ☐Lbs.

Occupation: ___________________________ Employer: __________________________________

Percentage of time at work: Sitting ___% Standing ___% Walking ___% Lifting Weights _____ %

Percentage of time at home: Barefoot _____ % Socks _____ % Slippers _____ % Shoes _____ %

Type of shoes most often worn: ☐ hiking/running ☐casual ☐dress ☐sandals ☐flats ☐ slippers

Ladies: Do you wear high heels? ☐At Work ☐ At Home ☐Occasionally ☐ Never

Turn Over to Complete Page 2 →→→→→→→→→→→

Former Podiatrist ______________________ Last Visit D/___ M/___ Y/ _______ ☐ N. A.
Have you ever worn Orthotics? ☐Y ☐N Do you currently wear Orthotics? ☐Y ☐N
I wear my current orthotics ____ hours a day on week days, ___ hours per day on weekends
My first pair of orthotics were made _____ years ago to help ____________________________________.
My last pair of orthotics were made _____ years ago to help ____________________________________.

Health Summary

I experience pain at: ☐Toes ☐ Ball of the Foot ☐ Top of the Foot ☐ Heels ☐ Legs
☐ Arches ☐ Ankles ☐Knees ☐Hips ☐ Lower back ☐ Neck ☐ Lateral aspect of the Foot

My feet/legs cramp, fatigue or tire easily. ☐ Y ☐ N
My ankles turn in or sprain easily. ☐ Y ☐ N
I have to stop activities because my feet hurt. ☐ Y ☐ N
Some of my family members have similar problems. ☐ Y ☐ N

My worst foot concern(s) is/are: ____
____

How would you describe your general health? ☐Excellent ☐Good ☐Average ☐Poor
Are you pregnant? ☐Y ☐N ☐There may be a possibility
If applicable, indicate type of birth control medication: _______________________________
Have you ever been treated for or suffered an allergic reaction to:

☐Anemia	☐Erythromycin	☐Liver Problem	☐Ulcers	☐Penicillin
☐Asthma	☐Gout	☐Phlebitis	☐Cancer	☐Sulpha
☐Adhesive Tape	☐Tylenol	☐Aspirin (ASA)	☐Novocain	☐Epilepsy
☐Poor Circulation	☐Diabetes	☐Codeine	☐Cortisone	☐Hepatitis
☐Rheumatic Fever	☐Difficulty Healing	☐Heart Problems	☐Kidney Problems	
☐Shortness of Breath		☐High Blood Pressure		

☐Other Allergies ____

Have you tested HIV positive? ☐Y ☐N Never been tested ☐
Are you subject to prolonged bleeding, healing or infection? ☐Y ☐N
Have you ever fainted in a dental office? ☐Y ☐N
Have you ever fainted giving blood? ☐Y ☐N
At present are you taking any medications? ☐Y ☐N
If so please list or provide a pharmacy report: ______________________________
Do you currently have any diseases or medical conditions? ☐Y ☐N
If yes please list: ____
Do you have a history of any serious surgery or medical problems? (I.e. heart surgery, hip replacement) ____

Consent

I hereby give my permission to Pierre Dupont, Doctor of Podiatry Medicine / Registered Chiropodist to examine and treat my feet medically, surgically or orthopedically. I acknowledge that fees for services are not covered by OHIP and are payable each treatment session. I also acknowledge the required reschedule or cancellation policy of two business day notice to avoid an office charge. Missed appointments will also be charged in full for the scheduled service reserved.

Signature: ______________________________ Date: ___________________________