Calgary Foot Clinic

121 14 Street N.W. Calgary, AB T2N 1Z6
Phone: (403) 266-2700 Fax: (403) 266-2900

Mr./Mrs./Miss./Ms. (please circle)

____ _______
(Last Name) (First Name) (Initial) Age

Address: ____ __________
(Number and Street) (City) (Province) (Postal Code)

Date of Birth (M/D/Y): ______________ Alberta Health Care Number: ______________

Home Telephone: ________ Work Telephone: _________ E-mail: _________________

Do you consent for us to send you e-mails such as appointment reminders or newsletters? Y / N

Weight:_____ Shoe Size: ____ Height: ______ Emergency Contact: ________________

Employer: ___________________ Occupation: _________________________

How did you hear about our office? _____________________________________

Is your foot problem a work-related injury? _____ Yes ______ No

Medical Information

Name of Family Physician: ____________________ Telephone Number: __________

Name of Former Podiatrist (if any): ______________ Approx date of last visit: _______

Briefly describe your **foot problems**: _____________________________________

____

What medicines do you take regularly? ___________________________________

Please list any **operations**: ____

If you have or have had any of the following, please place a **check mark** to the left of the item:

	Kidney Disease		Hardened Arteries		Poor Circulation		Raynaud's Disease
	Back Disorder		Liver Disease		Swelling Foot/Leg		Leg Cramps
	Numbness Foot/Leg		Diabetes		Stroke		Osteoporosis
	Hepatitis		AIDS		HIV Positive		Varicose Veins
	Broken Foot/Leg		Stomach Ulcer		Asthma		Epilepsy
	Cancer		Rheumatic Fever		Osteoarthritis		Rheumatoid Arthritis
	Tuberculosis		Heart Disease		High Blood Pressure		Anemia
	Blood DIsorder		Skin Disorder		Bleeding Disorder		Phlebitis - Leg

Please list any **Allergies** to Drugs, Medicines, or Materials: _______________________

Please describe any other major health problems: ___________________________

Signature: ______________________ Date: _____________