Newmarket Advanced
FOOT CLINIC & ORTHOTICS

Welcome to Newmarket Advanced Foot Clinic and Orthotics!
Please take a few moments to fill out the following information.
All information is confidential.

Personal Info

Name _____ Birthdate _____ Gender _____
First Last D/M/Y

Address _____
Street City Postal Code

Phone _____
Home Cell Work

Email _____ Health Card _____ VC _____

I provide consent to receive emails (we will never sell your information) ☐ Yes ☐ No

Contacts

Emergency Contact:

Name _____

Relationship _____

Phone _____

Family Doctor:

Name _____

Address _____

Phone _____

How would you like to receive appointment confirmations:

By email ☐ Yes ☐ No
By phone ☐ Yes ☐ No
By t`ext ☐ Yes ☐ No

Preferred pharmacy _____

Do you have health care benefits? ☐ Yes ☐ No ☐ Unknown ☐ ODSP ☐ OW ☐ Other

Insurance company _____

General Info

How did you hear about us? Whom may we thank for referring you? _____

What is the reason for your visit today? _____

Have you had previous Chiropody/ foot care? ☐ Yes ☐ No If yes, where? _____

Occupation _____ Approximate number of hours spent on feet per day _____

Weight _____ Shoe size _____ Type of footwear typically worn _____

How would you rate your level of activity? ☐ Low ☐ Average ☐ High

Do you wear footwear in the house? ☐ Yes ☐ No If yes, what type? _____

Have you used custom made orthotics? ☐ Yes ☐ No Did they provide relief? ☐ Yes ☐ No

The orthotics were obtained (year)_____ from (type of practitioner) _____

Medications

Are you taking any prescribed medication? If you have a list our office staff can photocopy it.

_____

_____

Are you taking any supplements? _____

☐ Yes ☐ No Do you need to take antibiotics before going to the dentist?

☐ Yes ☐ No Do you use Nitroglycerin? Where do you carry it? _____

Allergies

☐ No known allergies ☐ Penicillin ☐ Sulfa ☐ Silicone ☐ Latex
☐ NSAIDs (Advil, Aspirin) ☐ Betadine ☐ Cortisone ☐ Local Anaesthetics (Xylocaine)
☐ Adhesives, Tapes, Bandaids ☐ Other _____
Type of reaction: _____ ☐ Mild ☐ Moderate ☐ Anaphylaxis

Diabetes

☐ Yes ☐ No Do you have diabetes? *(If no, skip to Foot History)*
☐ Type 1 ☐ Type 2 Year diagnosed _____
☐ Yes ☐ No Do you monitor your blood sugar?
If yes, how often? _____
What is your blood sugar range? _____
☐ Yes ☐ No Do you suffer from diabetic neuropathy?
☐ Yes ☐ No Have you ever had a diabetic foot ulcer or infection?

Foot History

☐ Bunions ☐ Swelling ☐ Heel Pain ☐ Arch pain ☐ Hammertoes ☐ Forefoot Pain
☐ Gout ☐ Corns ☐ Flat Feet ☐ Neuroma ☐ Ankle Sprain ☐ Ingrown Nails
☐ Cramping ☐ Numbness ☐ Cracks ☐ Dry Skin ☐ Fungal Nails ☐ Joint Implant
☐ Discolored Nails ☐ Broken Foot/Leg ☐ Burning and Tingling
☐ Sweaty Feet ☐ Muscle weakness
☐ Childhood Foot Problems _____
☐ Other _____

Medical History

Please indicate if you have a history of the following conditions:
☐ Alzheimers ☐ Anemia ☐ Parkinson's ☐ Psoriasis ☐ Bleeding Disorder
☐ Blood clots ☐ Asthma ☐ Cellulitis ☐ Seizures ☐ Eczema/ Dermatitis
☐ Fibromyalgia ☐ Gout ☐ Kidney disease
☐ HIV/ AIDS ☐ COPD ☐ Hearing loss ☐ Liver disease
☐ Hepatitis A/B/C ☐ Pacemaker
☐ Vision loss ☐ Thyroid disease ☐ Schizophrenia
☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Stroke: year _____
☐ Osteoporosis/ Osteopenia ☐ Hives/Rashes ☐ Heart Attack: year _____
☐ Heart condition: explain _____
☐ Cancer: Type _____ ☐ Chemotherapy ☐ Radiation
☐ Other conditions not listed above _____

Risk Factors

☐ Yes ☐ No Do you have a history of falls?
☐ Yes ☐ No Do you consider yourself to be a good healer?
☐ Yes ☐ No Do you have any problems with your immune system?
☐ Yes ☐ No Have you had any serious illness, been admitted to the hospital, or had any surgeries?
Please indicate when and why: _____

_____

☐ Yes ☐ No Do you smoke or have you ever smoked?
How many do/did you smoke per day?_____
How old were you when you started? _____ When did you quit? _____
☐ Yes ☐ No Do you drink alcohol? If yes, how many drinks per week? _____

Circ

☐ Yes ☐ No Do you have or have you been treated for varicose veins? If yes, when? _____
☐ Yes ☐ No Have you worn or do you currently wear compression stockings?
☐ Yes ☐ No Do you have poor circulation?
☐ Yes ☐ No Does it affect your legs or feet?

Family History

Please indicate any of the following disease or conditions of **immediate members of your family:**
☐ Psoriasis ☐ Eczema ☐ Cancer ☐ Diabetes ☐ COPD ☐ High blood pressure
☐ Bunions ☐ Stroke ☐ Asthma ☐ Flat feet ☐ Gout ☐ Rheumatoid arthritis
☐ Heart disease ☐ Vascular disease ☐ Other:_____

Is there anything else that you feel may be important for us to know?

_____

Please update us of any changes to your medical status at future appointments
Failure to disclose information could result in inaccurate treatment being undertaken