

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth (D/M/Y) \_\_\_\_\_ Email Address \_\_\_\_\_

Phone (H) \_\_\_\_\_

(Cell) \_\_\_\_\_ (Business) \_\_\_\_\_

Would you like us to confirm your appointments by Email :  Yes  No

Phone:  Yes  No

Do you have Extended Health Care Insurance?  Yes  No

Name \_\_\_\_\_

How did you hear about our office?

Friend/family/colleague \_\_\_\_\_

(please indicate referrer's name so we may thank them)

Internet  Newspaper/Article  Health care professional/ Family Doctor \_\_\_\_\_

Yellow pages  Gold Book  Other (please specify) \_\_\_\_\_

**Your current foot problem involves:**

Right Foot Only  Left Foot Only  Both Feet

**Please explain:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Have you ever been treated for: (check all that apply)**

- Back pain
- Gout
- Warts
- Broken foot/leg bones
- Heel pain
- Flat feet
- Ankle injury
- High arch feet/pain
- Corns
- Neuroma
- Callouses
- Knee pain
- Bunions
- Ingrown nails
- Hammertoes
- Childhood Foot Problems

**What is your current:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

What type of footwear do you wear most for work or leisure?

Safety shoe/boot  Athletic  Dress  Sandal

Other \_\_\_\_\_

**Do you currently use orthotics (shoe inserts)?**  Yes  No

Check any sports or activities you participate in regularly:

Walking  Running

Aerobics/Aqua Fit  Golf

Hockey  Soccer

Racquet Sports  Skiing

Other: \_\_\_\_\_

**Please answer the following questions**

**Do you have or have you ever been treated for:**

**(Check all that apply)**

- Diabetes: Type 1 Type 2 How Long? \_\_\_\_\_
- Heart Trouble       Skin Disorder
- Hepatitis             Thyroid Problem
- Liver Disease       HIV/AIDS
- Urinary Problem    Blood Disease
- Stroke                Stomach/Bowel Trouble
- Depression          Anxiety
- Bone Disease        High Blood Pressure
- Cholesterol          Arthritis
- Cancer               Epilepsy
- Tuberculosis        Shortness of Breath
- None Apply          Other: \_\_\_\_\_

**Please list your current Rx medications:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Do you have any known allergies to:**

Local anesthetics? (e.g. Xylocaine, Novocaine)  Y  N

Adhesive tape/band-aids?  Y  N

No allergies known:  Y  N

Other: \_\_\_\_\_

Are you slow to heal after cuts?  Y  N

Do you bruise easily?  Y  N

Do you currently have a pace maker ?  Y  N

Do you currently have a hearing aid ?  Y  N

Do you have any electronic implants ?  Y  N

Are you currently pregnant or nursing?  Y  N

**Patient Physicians**

Family Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Has your doctor treated your foot condition?  Y  N

Did this doctor refer you to us?  Y  N

**Patient's Consent:**

I hereby allow and consent to examination and treatment by *J D Cowen Foot & Ankle Clinic* and allow photographs of treatment areas be taken for the purposes of monitoring.

I consent/allow *J D Cowen Foot & Ankle Clinic* to contact my physician for any pertinent information required relating to my treatment or medical information.

I consent/allow *J D Cowen Foot & Ankle Clinic* to send my physician or health care professional a report regarding my foot exam and treatment plan.

I understand that I am financially responsible for all charges whether covered by my health insurance plan or not .  
 I understand that service fees are payable at the time service is provided.

Patient's Signature (or guardian): \_\_\_\_\_ Date: \_\_\_\_\_