SASKATOON FAMILY PODIATRY

New Patient Form

Title		First Name		Last Name			
Date of Birth (M/D/Y)				Healthcard Number			
Gender							
Address						Postal code	
						Occupation	
Phone numbers (home):		(cell):				(work):	
Email address				Next of kin Name & contact no.			
Family Doctor				Address			
Additional Government Coverage (social services or NIHB)							
Height		Weight				Shoe size	

How did you hear about our clinic?

☐ Referred by Dr/Healthcare specialist ☐ Friend/Family suggestion ☐ Internet search

☐ Social Media ☐ Other (please specify) .....

Reason for Visit today:

.....

Previous Foot Surgery/Podiatry treatment/Joint Replacements:

.....

Medical History

Medications (Prescription and non-prescription, please write on the back if more space is required):

.....

.....

Allergies:

.....

Do you currently smoke? Yes No Have you ever smoked? Yes No

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Please circle yes or no to the questions below and give further details in the space provided at the end of the form. Do you have or have you had any of the below:

Illness in the last 6 months	Yes	No	Other illness/operations	Yes	No
Diabetes	Yes	No	History of fainting conditions	Yes	No
Endocrine Disorder or Condition	Yes	No	Hepatitis/jaundice/renal disease	Yes	No
History of leg/foot ulcers	Yes	No	Neurological condition	Yes	No
Numbness in feet	Yes	No	Memory problems	Yes	No
Epilepsy	Yes	No	Skin conditions e.g. psoriasis	Yes	No
Cancer	Yes	No	Musculoskeletal problems	Yes	No
Rheumatoid Arthritis	Yes	No	Fractures	Yes	No
Heart disease/angina/heart attack	Yes	No	Any falls in the last 6 months	Yes	No
Pacemaker	Yes	No	Respiratory problems	Yes	No
Rheumatic fever	Yes	No	Mental Health Diagnosis	Yes	No
High blood pressure	Yes	No	Genetic Condition	Yes	No
Blood clot/Varicose Veins	Yes	No	Vision Problems	Yes	No
Peripheral Vascular Disease	Yes	No	Hearing Problems	Yes	No
Blood disorders	Yes	No	Alcohol dependency	Yes	No
Abnormal bleeding after surgery	Yes	No	Drug dependency	Yes	No
HIV/Hepatitis B/Hepatitis C	Yes	No	Attending any Specialist clinics	Yes	No
Delayed healing/sepsis	Yes	No	Currently pregnant	Yes	No
MRSA	Yes	No	Any other medical conditions	Yes	No

If you have answered Yes to any of the above please provide more detail (use the other side of the form if needed):.....

Consent to being treated by a Podiatrist(s)

I understand that I am to be seen/treated by a Podiatrist(s). I confirm that I am aware that Podiatrists may use medical instruments including nail nippers, scalpel, files and burrs. I understand that my information is confidential. I understand that it is my choice what information I provide, but that withholding or falsifying information may have a negative outcome on my Podiatry treatment. I consent to allow Saskatoon Family Podiatry to collect further information related to my treatment including x-rays, medical reports, E-Health medical record. I understand that I am finally responsible for any balance due on my account. I understand that I am not permitted to take pictures/video of the procedures being performed.

Signed ..... Print Name .....

Parent/Guardian signature if under Age 16 ..... Date .....