



Confidential Registration Questionnaire

Please complete this questionnaire as it will be used to open your file.
All the information will remain confidential.
All this information is required by the Quebec Podiatric law.

Last name (maiden) : _____ **Day** _____ **Month** _____ **Years** _____

First name : _____ **Date of birth :** ____/____/____

Address : _____ **Age:** _____

City : _____ **Sex:** Male Female

Postal Code : _ _ _ _ _ **For an emergency, contact :** _____

Home phone : _____ **Phone number :** _____

Work phone : _____ **No d'ass. maladie :** _____

Cellular : _____ **If you are less than 18 years old, indicate name of parent or guardian :** _____

E-mail: _____

COMPLAINTS

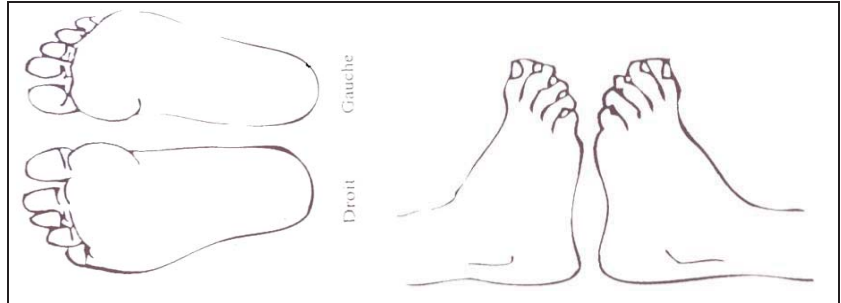
Reason for consultation : _____

Description of pain (acute, chronic, localised, referred, numbness...): _____

Duration of pain: ___ Days ___ Months ___ Years

Frequency of pain: _____ **Localisation :** _____

- Upon standing When walking
 At bedtime Post activity
 Other : _____



OTHERS

Measurements : Height _____ Weight _____ Foot size _____ **What is your occupation?** _____

Do you have insurance? Yes Name : _____ No I don't know

You were referred by?

- Internet (Yellow pages) Friends-family Courier Ahuntsic The Suburban Laval News
 Internet (our web site) Yellow pages Courier Laval The Chronicle Doctor : _____

Do you have a family doctor? Yes No

Doctor's Name: _____ **Phone:** _____ **Ext:** _____

Are you presently under a doctor's care? Yes No **Doctor's Name:** _____ **Phone:** _____

PODIATRIC HISTORY

Last visit: 0-6 months 6-12 months More than 12 months

Have you previously had podiatric treatments such as?

	Yes	No		Yes	No		Yes	No
Orthotics	<input type="checkbox"/>	<input type="checkbox"/>	Ingrown toe nail	<input type="checkbox"/>	<input type="checkbox"/>	Warts	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Corn/Callus	<input type="checkbox"/>	<input type="checkbox"/>	Pain in heel	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY

Yes No

- 1 Are you presently taking any drug or medication, or have you taken any in the last six months
Which _____

- 2 Are you presently taking natural or homeopathic products
Which _____
- Birth control pills
- Hormones
- 3 Did you recently experience a significant weight loss or gain
- 4 Are you pregnant
Breastfeeding
Are you suffering or have you ever suffered from:
- 5 Heart disease (stroke, angina, valvular problems, murmur)
- 6 Rheumatic fever
- 7 Blood problems
Haemophilia Anaemia
Prolonged bleeding Other, Which : _____
Clear blood
- 8 Blood pressure : High Low No
- 9 Tuberculosis or lung problems
- 10 Stomach ulcer
- 11 Digestive problems Which _____
- 12 Liver disease (Hepatitis A, B, C, cirrhosis, etc)
- 13 Kidney problems
- 14 Do you urinate often
- 15 Venereal disease (V.D.)
- 16 Diabetes
- 17 Thyroid problems
- 18 Skin disease
- 19 Arthritis
- 20 Eyes problems
- 21 Epilepsy
- 22 Osteoporosis
- 23 Mental illness
- 24 Nervous problems

Yes No

- 25 Frequent headaches.....
- 26 Dizzy spells or fainting spells
- 27 Hay fever
- 28 Asthma
- 29 Have you ever had radiotherapy or/and chemotherapy treatments (tumor)
- 30 Do you have AIDS symptoms
- 31 Are you an AIDS virus carrier
- 32 Other pathologies present
Heart Gout
Phlebitis Varicose veins
Nervous disease Psoriasis
Polio Vascular disease
- 33 Do you smoke
- 34 Do you have artificial joints (knee, hip, etc)
- 35 Do you have any of the following allergies
Latex Penicillin
Sea food Codeine
Aspirin Other antibiotics
Sulfa Local anesthesia
Iodine Other : _____
- 36 Do you use drugs.....
- 37 Do you drink alcohol
No/ A little In moderation A lot
- 38 Were you ever hospitalize or have you undergone surgery.....
Which and when

- 39 Have you had injuries (fractures, spains, ect) in the past.....

AGREEMENT AND CANCELLATION POLICY

You must advise us at least 24 hour in advance when it's impossible to respect an appointment that has been confirmed.
Missed appointment without 24 hours notice: Fees are charged (45\$)

I declare that the information above is accurate and **complete**. Additionally, I authorize my podiatrist to transmit and disclose my medical information to my insurance for reimbursement purposes and / or my physician, if necessary. I additionally agree to the cancellation policy of the clinic.

Signature

Date

If the is a minor, please write the name of the guardian: _____