Date:__/___/ 20____

Dre Louana Ibrahim
Clinique Podiatrique LE CARREFOUR

INSCRIPTION FORM

Please fill out this form, for the completion of your file.
The information below is CONFIDENTIAL

Maiden Name: _____ First name: _____ Date of birth: ___/___/___
Day / Month / Year
Address: _____ Tel. Home : _(___)_____ Age: ____
_____ Tel. Work : _(___)_____ Sex: M□ F□
Postal Code __ __ __ __ __ __
For a child, the guardian should sign and write his/her name : _____

Refered by: □ Physician □ Friends/Family □ Yellow pages Newspapers: □ Courrier Laval □Other:_____
Dr. _____ □ Ahuntsic

Height _____ft _____in Weight _____lbs Foot size _____ Width _____
_____cm _____kgs

Insurance : □ yes □ none □ uncertain Company : _____

Occupation : _____

Family physician : _____ # tel: _____

Allergies to medication: □ yes □ none If yes, name the medicine: _____

List of medicine in use: _____
_____

Surgeries or fractures in the past: _____
_____

Pathologies : □ None
□ Heart □ Diabetes □ Phlebitis □ Polio □ Varicose
□ Rhumatoid □ Arthritis □ Gout □ Kidneys □ Hypertension
□ Hemorragy □ Nervous syst. □ Vascular syst. (circulation)
□ Other _____

Reason for the consult: (Pain, Ingrown nails, Warts, Surgical evaluation…)
_____
_____

Description of the pain: (Chronic, referred, local…) : _____
Location (Left or right, foot, ankle, heel, arch, knee, back…) : _____
Since: _____days _____weeks _____months _____years
When: □ in the morning □ at bedtime □ post activity

PODIATRIC TREATMENTS ARE NOT COVERED BY THE '' REGIE DE L'ASSURANCE MALADIE DU QUEBEC''.