

**PLEASE COMPLETE FORM AND GIVE TO RECEPTIONIST ON ARRIVAL**

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SURNAME	FIRST NAME	Birthdate DD/MM/YYYY
ADDRESS		POSTAL CODE
HOME PHONE	WORK PHONE	
EMAIL ADDRESS		
PRIMARY CARE PHYSICIAN	CLINIC	
WHO MAY WE THANK FOR REFERRING YOU ?		
PATIENT CAREGIVER CONTACT DETAILS WHERE RELEVANT:		

PLEASE HIGHLIGHT ANY OF THE FOLLOWING WHICH MAY AFFECT YOU.

- |                   |                   |                |               |              |
|-------------------|-------------------|----------------|---------------|--------------|
| DIABETES MELLITUS | ARTHRITIS         | STROKE POOR    | EYESIGHT POOR | HEARING      |
| FOOT/LEG SURGERY  | LOSS OF SENSATION | LU             | NG DISEASE LI | VER DISEASE  |
| SKIN DISEASE      | ASTHMA            | EPILEPSY       | HEART DISEASE | CHEMOTHERAPY |
| POOR CIRCULATION  | DIALYSIS          | KIDNEY DISEASE |               |              |

OTHER DISEASES WHICH HAVE AFFECTED YOU IN THE PAST 10 YEARS:

DO YOU USE STEROID OR ANTICOAGULANT DRUGS ?

DO YOU HAVE ANY DRUG ALLERGIES ?

PLEASE LIST CURRENT MEDICATION:

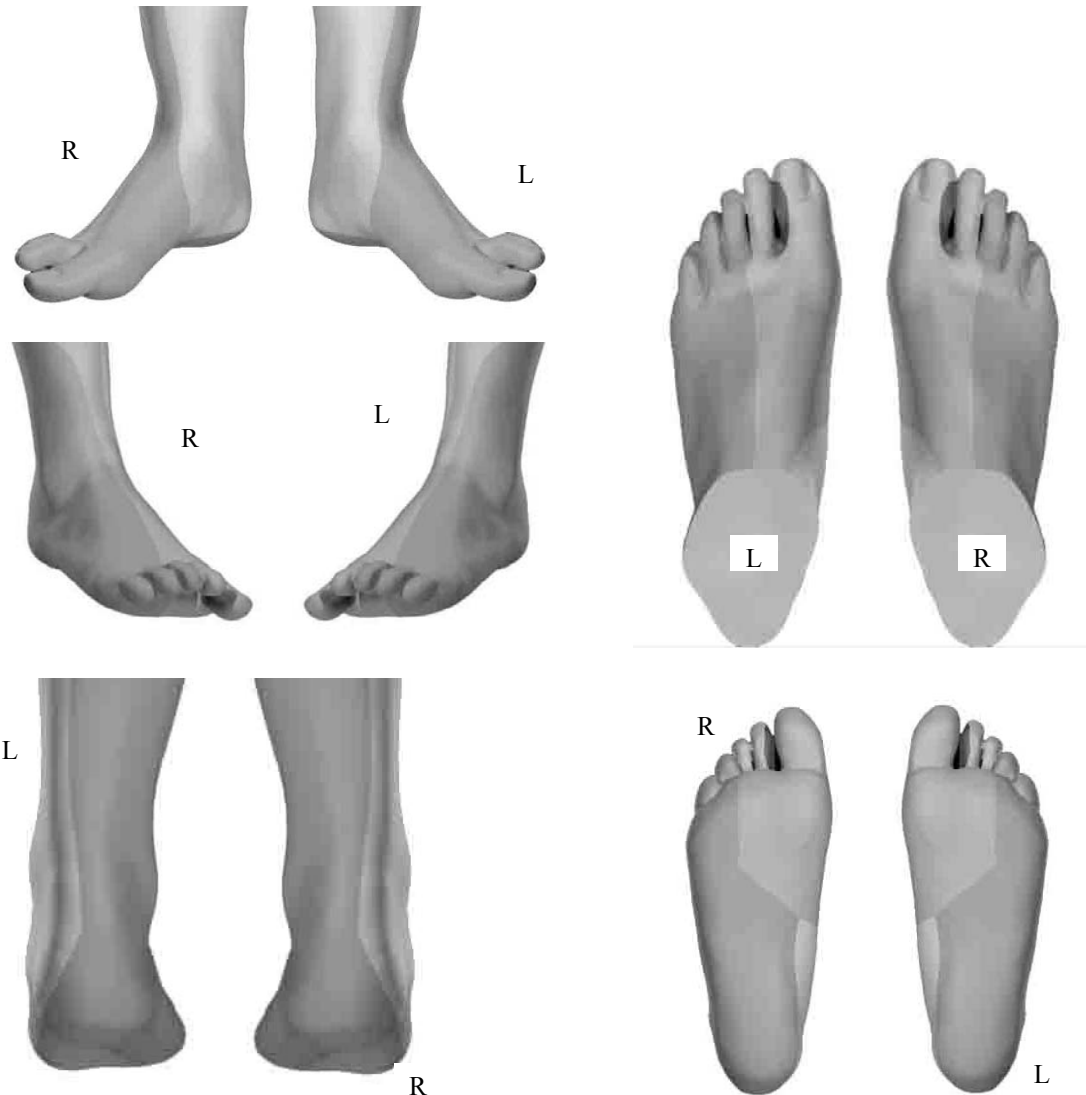
I understand that podiatric services are not covered by Manitoba Health Services Commission (Medicare) and that payment for these services is my responsibility:

signed \_\_\_\_\_

date \_\_\_\_\_

NAME \_\_\_\_\_

**If you have foot pain please mark the site with an arrow for a specific location or shade an area for more diffuse pain. If you have more than one site of pain mark the sites A B C etc.**



The line below represents a linear pain scale. Please place a mark across the line corresponding to the level of pain experienced on the day of your clinic visit.

If you have more than one pain site, mark with corresponding A B C of arrows on diagrams above.

