PLEASE COMPLETE FORM AND GIVE TO RECEPTIONIST ON ARRIVAL

Dr Martin Colledge and Michelle McLatchie Podiatrists
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Phone 837 FOOT (3668)

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 LUNG DISEASE LIVER DISEASE
SKIN DISEASE ASTHMA EPILEPSY HEART DISEASE CHEMOTHERAPY
POOR CIRCULATION DIALYSIS KIDNEY DISEASE

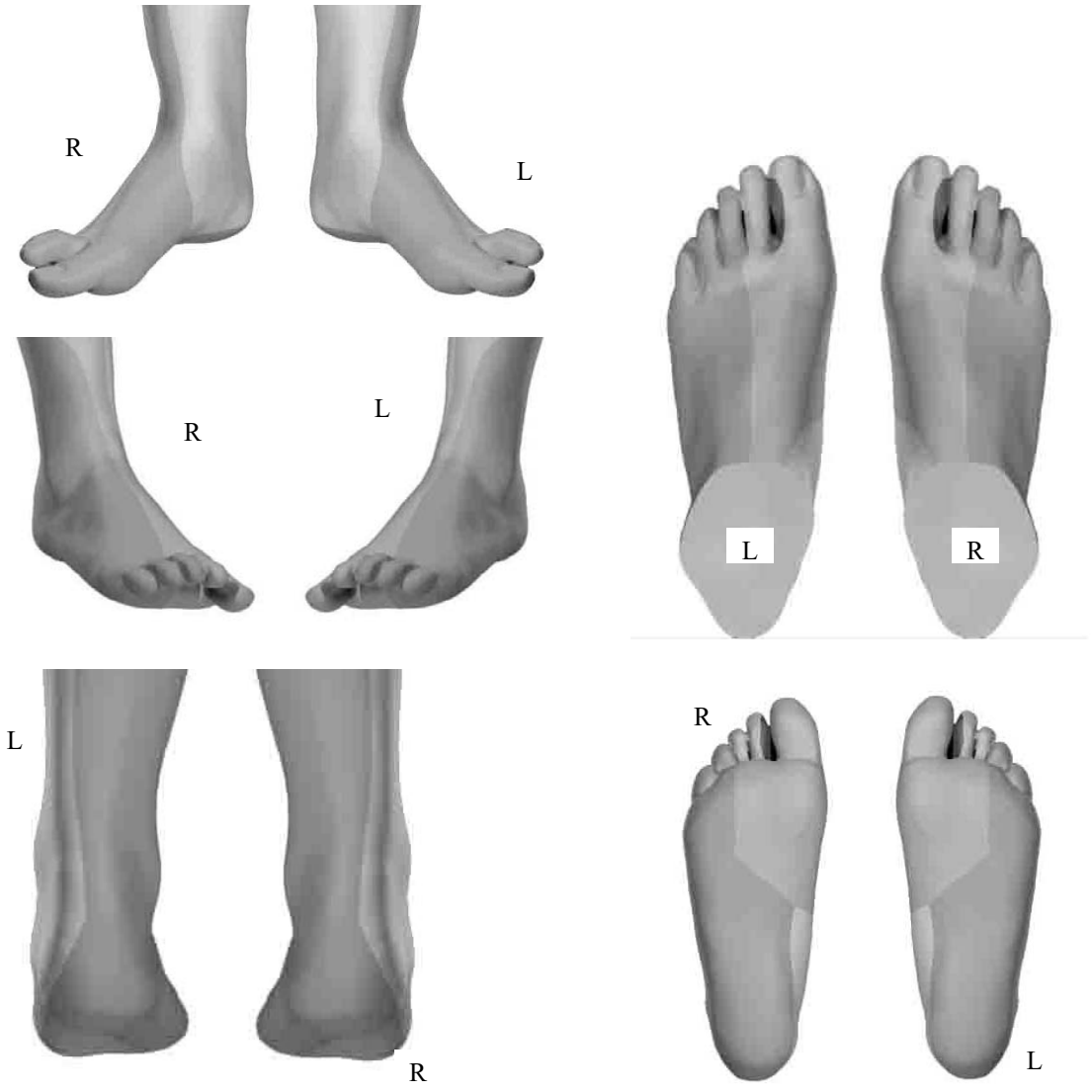
OTHER DISEASES WHICH HAVE AFFECTED YOU IN THE PAST 10 YEARS:
DO YOU USE STEROID OR ANTICOAGULANT DRUGS ?
DO YOU HAVE ANY DRUG ALLERGIES ?
PLEASE LIST CURRENT MEDICATION:

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.

Worst Imaginable Pain ——————————————— **No Pain**