Dorval Podiatric Clinic
667 Bord-du-Lac, Dorval, H9S 2B7
514-686-4557

Welcome to Clinique Podiatrique Dorval

File: _____ Date:_____
First name: _____
Last name: _____

Please note that all information collected in the registration form will remain confidential.

Date of birth (year/month/day): _____ Age: _____ ☐ **Female** ☐ **Male**

Address: _____ **Home phone number: _____**
City: _____ **Cell phone number: _____**
Postal Code: _____ **Work phone number: _____**
Email: _____
Family doctor: _____ **His/her City: _____**

How did you hear about the clinic? ☐ Newspaper ☐ Web site ☐ Outdoor display ☐ Referral by family/friend _____
☐ Doctor's referral Who? _____

Medical History :

Allergies/intolerances to drugs or other check if applicable. No allergies

☐ Iodine ☐ Local anesthetics ☐ Latex ☐ Codeine
☐ Anti-inflammatory ☐ Band-Aid ☐ Sulfa
☐ Other: _____

List all medications, herbal supplements and / or vitamins you take: ☐ **None**

_____

List all operations, injuries or hospitalizations: ☐ **None**

_____

Do you smoke? ☐ Yes ☐ No - If you do, how many cigarettes per day? ___ How long have you been a smoker ?____/year
Have you ever smoked? ☐ Yes ☐ No – How long ago have you stopped? ____ month/year
Do you drink alcohol? ☐ Yes ☐ No - If so, specify ____glass/day OR _____ glass/week
Do you take drugs? ☐ Yes ☐ No – If so, which substance? _____ Frequency_____

Check if you have already been diagnosed with one of these diseases or conditions:

☐ Diabetes
☐ Rhumatoid Arthritis
☐ Osteoarthritis
☐ Kidney problems
☐ Hypertension (high blood pressure)
☐ Gout
☐ Hypothyroidism
☐ Fibromyalgia
☐ Cholesterol
☐ Hemorrhaging
☐ Skin problems (eg: eczema, psoriasis, infection of the skin or nails)
☐ Respiratory problems (eg: asthma, pulmonary disease)
☐ Cardiac condition (eg: heart attack, angina, arterial blockage)
☐ Problem affecting the brain (eg: stroke)
☐ Neurological problems (eg: polio, parkinson, cerebral palsy, multiple sclerosis)
☐ Poor blood circulation (eg: leg swelling, varicose veins, phlebitis, Raynaud's disease)
☐ Digestive problems (eg : ulcers, Crohn disease)
☐ Sexually transmitted deieases (eg: AIDS, siphyllis, chlamydia, herpes)
☐ Mental health problem:_____
☐ Cancer - if so, specify which one: _____
☐ Other: _____

☐I am pregnant- Months: _____/ weeks_____ ☐ I breastfeed

Please note that Podiatric consultations are not covered by the Quebec Health Insurance.

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File: _____ Date:_____
First name: _____
Last name: _____

Do you practice sports? ☐ Yes ☐ No - which ones? _____
What is you occupation?_____ ☐ Standing ☐ Sitting ☐ Retired
Measurements:
Height: _____ft _____in OR _____cm Weight: _____lbs OR _____kg Shoe size: _____

Reason for consultation:

☐ Biomecanical evaluation
☐ Orthosis
☐ Corn
☐ Plantar wart
☐ Sport injury
☐ Pain
☐ Ingrown Toe Nail
☐ Callus
☐ Evaluation for Surgery
☐ Nail cut
☐ Foot care
☐ Other: _____

Type of pain:

☐ Burning ☐ Electrical discharge ☐ Tingling ☐ Needle
☐ Shooting pain ☐ Numbness ☐ Pinching

When do you feel it:

☐ In the morning ☐ At rest ☐ Always
☐ While walking ☐ At night

Where do you feel it: _____

How long has the pain been present?

Have you started treatment for this problem? ☐ Yes ☐ No - which one? _____

Do you have insurance that covers podiatric care? ☐ Yes ☐ No

Clinic Policies:

You must notify us at least 24 hours in advance when you can not attend your appointment. A $45 fee will be charged for missed appointment without warning.
I authorise the podiatrist to take pictures of my feet to add to my medical file.
I accept the cancellation policy. I declare that the information provided in this questionnaire is accurate and complete. I authorize my podiatrist to transmit and disclose my medical information to my insurance (if you have any) for purposes of reimbursement and to my family doctor when medically required. The podiatric clinic is private. I understand that the podiatric costs are not covered by the RAMQ and agree to pay the fee at the end of each visit.

Signature: _____ Date: _____

Name of parent or guardian: _____

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