Alliston Foot & Orthotic Clinic

Patient Identification & Medical History Form

Name:_____ Date of Birth: _____
(mm/dd/yyyy)

Address: _____ City:_____

Postal Code:_____ Email : _____
email will be used by us only and to confirm appointments

Telephone:_____ _____ _____
Home Cell Work

Preferred Contact Method (circle): Home / Cell / Work / Email

Physician Name: _____ City:_____ Phone# _____

Insurance Company:_____ Policy #:_____ Plan ID#_____

Policy Holder Member Name:_____ D.O.B_____

In Case of Emergency, we should notify:

Name:_____ Phone#:_____ Relationship:_____

How did you hear about our clinic?

□ Physician □ Location/Walk-by □ Family-Friend □ Other Health Care Provider
□ Website □ Facebook/Social Media □ Newspaper □ Other:_____

What brings you to see us today?_____

_____

Are you taking any medications, non-prescription drugs of any kind? If ☐ YES , please list or provide copy. ☐ **NO**

_____

_____

Do you take any blood thinners? Aspirin or others ☐ **YES** ☐ **NO** Do you take birth control medications? ☐ **YES** ☐ **NO**

Do you have any ALLERGIES? ☐ **NO** **If ☐ YES, please list:**

□ Aspirin □ Codeine □ Ibuprofen/NSAIDs □ Sulfa □ Local Anesthetic
□ Penicillin □ Steroids □ Adhesives/tape □ Iodine □ Elastoplasts
□ Latex □ Other:_____ □ Type of reaction _____

Do you have or have you ever been diagnosed with any of the following? ☐ **NO**

□ **Diabetes:** Year Diagnosed:_____
- □ Insulin Dependent Type 1
- □ Non Insulin Dependent Type 2
- □ Diet Controlled- Borderline

Last A1C test:_____ Control Level: □ poor □ good □ great

□ **Arthritis** Joints Affected:_____
- □ Osteo
- □ Rheumatoid
- □ Psoriatic

□ **Heart Attack** year:_____ □ **Stroke** year:_____ side affected:_____

□ **Angina/Chest Pain: Nitroglycerine use**: □ **NO** □ **YES** Where do you carry it?_____

I have provided up-to-date information and will advise of any changes in my personal and medical information at each visit.

Signature Patient/Guardian: _____ **Date:**_____