Alliston Foot & Orthotic Clinic
Patient Identification & Medical History Form

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

Gender: (circle) Male / Female / Non – Binary / Other: _____ I Identify as: _____

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

Family Doctor's 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?_____

Preferred Pharmacy:_____

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:_____ □ **Arthritis** Joints Affected:_____
□ Insulin Dependent Type 1 □ Osteo
□ Non Insulin Dependent Type 2 □ Rheumatoid
□ Diet Controlled- Borderline □ Psoriatic
Last A1C test:_____ Control Level: □ poor □ good □ great

□ **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:**_____

Alliston Foot & Orthotic Clinic
Medical History and Foot Examination

Initial / Re-Assessment

Name: _____ Date: _____

Review of Systems

□ Kidney disease
□ Liver disease
□ Thyroid disease
□ Osteoporosis/ Osteopenia
□ Asthma – COPD - Emphysema
□ Psoriasis – Eczema - Rash/skin problem
□ Blood Clots - Varicose veins
□ High/Low blood pressure
□ Congestive Heart Failure
□ Pacemaker – Irregular heart arrhythmia
□ Mitro-valve prolapsed – valve replaced
□ Gout
□ Muscular Dystrophy – Multiple Sclerosis
□ Fibromyalgia
□ Anxiety – Depression – Claustrophobia
□ Spina bifida – Cerebral Palsy
□ Spinal Stenosis
□ HIV/AIDS - Hepatitis A/B/C
□ Seizures - Epilepsy
□ Bleeding Disorders
□ Stomach Ulcer - Acid Reflux - Crohn's / Colitis
□ Pregnancy
□ Cancer
□ Other:_____
_____

Surgeries:_____

Fractures/Broken Bones:_____ Any past ankle sprains? □ YES □ NO

NOTES: _____

Employment Status
□ Not Working: Home/Retired/Disable/Student
□ Occupation_____
□ Full time □Part-time □ Occasional

%typical day:
Standing_____%
Walking_____%
Sitting_____%

Sport & Activities. List:
_____
_____
□ Summer □ Winter □ All the time
Times/Week_____ Min/Km:_____

Physical Attributes
Height _____ Weight_____Shoe Size_____
Past 6 months any weight □ gain □ loss How much?_____
#___childbirths. Are you currently pregnant? □ Yes □ No

Footwear
What type of shoes worn most of the time?_____
□Work boots □ Running shoes □ Slip-ons
□Flats □ Heels ___" □ Walking shoes
□ Sandals □ Laced □ Other:
What do you wear inside the house?_____

Social History

Alcohol Usage: □ Yes □ No □ Previous Use **Cigarette/Tobacco Use**: □ Yes □ No □ Previous Use

Foot History & Information

Any Family members who have had: Diabetes_____ Foot Problem_____

Have you ever had your feet examined before by a:
□ Family physician □ Chiropodist/Podiatrist □ Orthopedic Surgeon □ Pedicurist □ Other:_____

Did you previously or do you now wear:
Over the counter insert? □ Yes □ No Still using them? □ Yes □ No Do or did they help? □ Yes □ No
Custom made orthotics? □ Yes □ No Still using them? □ Yes □ No Do or did they help? □ Yes □ No
The orthotics were obtained (year)_____ from (practitioner) _____

Foot Screening:
Do you ever get calf or leg cramps? □ Yes □ No When?: Day while walking / Night time
Do you feel your feet are cold or hot? □ Yes □ No
Are your feet or toes ever numb? □ Yes □ No
Do they ever tingle? □ Yes □ No
Do they ever burn? □ Yes □ No
Or feel like insects are crawling on them? □ Yes □ No

NOTES: _____

Assistant: _____