Please answer the following questions fully to help us become better acquainted. Please print!

NAME_____DATE OF BIRTH_____

HOME ADDRESS_____CITY_____

POSTAL CODE_____ HEALTH CARD_____EXP_____

TELEPHONE HOME_____CELL_____

TELEPHONE WORK_____ EMAIL_____

REFERRED BY_____ OCCUPATION_____

FAMILY PHYSICIAN_____ ADDRESS_____

_____

_____

WHAT IS YOUR FOOT COMPLAINT:_____

HOW LONG AGO DID THIS PROBLEM START? DAYS WEEKS MONTHS YEARS

DID YOUR PAIN OR PROBLEM?_____BEGIN SUDDENLY or____GRADUALLY DEVELOPED

HOW WOULD YOU DESCRIBE YOUR PAIN?___SHARP,___DULL,___ACHING,_____OTHER

WHAT MAKES THE PROBLEM WORSE?_____

WHAT MAKES THE PROBLEM BETTER?_____

HAVE YOU TRIED OTHER TREATMENTS? ____ YES_____ _____NO

HOW MUCH ARE YOU ON YOUR FEET AT WORK?___10%___25%___50%___75%___100%

EXERCISE?_____NEVER_____OCCASIONALLY_____WEEKLY_____DAILY

TYPE OF EXERCISE_____

MEDICAL HISTORY:

ARE YOU CURRENTLY BEING TREATED FOR A SPECIFIC MEDICAL PROBLEM ?_____YES____NO

ARE YOU ALLERGIC TO MEDICATIONS OR MATERIALS? _____LOCAL ANESTHETICS_____LATEX

_____PENICILLIN _____ADHESIVE TAPE_____OTHER_____

ARE YOU TAKING ANY MEDICATIONS?_____

CONTINUE ON OTHER SIDE:

IS THERE A PERSONAL OR FAMILY HISTORY OF DIABETES?_____YES _____NO

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS?_____ YES _____NO

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

HEART PROBLEMS_____ ASTHMA_____ ULCERS_____EPILEPSY_____ TB_____

KIDNEY PROBLEMS_____LIVER PROBLEMS_____ARTHRITIS_____PHLEBITIS_____

CANCER_____ RHEM ARTHRITIS_____HIGH or LOW BLOOD PRESSURE_____

HAVE YOU EVER HAD SEVERE CHEST PAINS OR SHORTNESS OF BREATH?_____YES_____NO

ARE YOU SUBJECT TO PROLONGED BLEEDING? _____YES_____NO

DO YOU HAVE PROBLEMS HEALING? _____YES _____ NO

ARE YOU PRONE TO INFECTION? _____YES_____NO

HAVE YOU EVER FAINTED IN A DOCTOR OR DENTIST OFFICE? _____YES _____ NO

DO YOU HAVE LOW BACK PAIN? _____YES_____ NO

FEMALES: ARE YOU PREGNANT? _____YES_____ NO

EXTENDED OR SUPPLEMENTARY INSURANCE? COMPANY:_____

POLICY #_____CERTIFICATE#_____

I HEREBY GIVE PERMISSION TO RONALD J. KLEIN D.P.M., TO ASSESS, RECOMMEND, DISCUSS AND ADMINISTER TREATMENT FOR MY FOOT CONDITION AS DEEMED NECESSARY.

I UNDERSTAND THAT RONALD J. KLEIN D.P.M. IS A DOCTOR OF PODIATRIC MEDICINE AND NOT AN MD, SUBSEQUENTLY THERE IS A FEE FOR THE EXAMINATION AND TREATMENT.

_____ _____

DATE SIGNATURE

1) HAVE BEEN DIAGNOSED WITH, OR BEEN IN CONTACT WITH SOMEONE WITH COVID-19 IN THE PAST 14 DAYS? _____YES _____NO
2) HAVE YOU TRAVELED OUT OF THE PROVINCE IN THE PAST 14 DAYS? _____YES _____NO
3) ARE YOU PRESENTING SYMPTOMS CORRESPONDING TO COVID-19, FEVER, DRY COUGH, SORE THROAT, DIARRHEA? _____ YES _____ NO
4) HAVE YOU VISITED OR BEEN IN CONTACT WITH ANYONE IN A LONG TERM CARE HOME OR HOSPITAL? _____YES _____ NO