Hibbert & Associates
Foot Clinic

PATIENT INFORMATION FORM

Welcome! We're dedicated to providing exceptional footcare for people of all ages. Please help us get to know you better by providing the following information.

First Name: _____ Last Name: _____

Address: _____ City: _____ Postal Code: _____

Phone (cell): _____ Phone (home): _____

Date of Birth: M/_____D/_____Y/_____ Email: _____

Occupation: _____ Referred by/How you found us: _____

How would you like us to contact you? ☐ home phone ☐ cell ☐ email

Family Physician: _____ Other Specialist: _____

Emergency Contact: _____ Relationship & Phone: _____

Help us help you! Please answer the following questions:

1. What brought you here today, explain your foot concern(s):

_____

2. How is your general health? ☐ Good ☐ Fair ☐ Poor

3. Are you taking medication at this time? ☐ No ☐ Yes If yes, please have a list of medications available.

4. Have you ever been to a chiropodist/foot specialist? ☐ Yes ☐No

5. Have you ever been treated for any of the following? Please check

☐ Diabetes ☐ Heart Issues/Stroke ☐ Rheumatic fever ☐ Breathing problems

☐ Stomach ulcer ☐ Kidney/Liver problems ☐ Circulation problems ☐ High/low blood pressure

☐ Cancer ☐ Arthritis/Gout ☐ Neurological disorders ☐ Slow in healing

☐ Thyroid ☐ Epilepsy/blackouts/fainting ☐ Skin conditions ☐ Autoimmune disorders

☐ Disability: _____ ☐ Communicable disease: _____

6. Is there any family history of Diabetes? ☐ Yes ☐ No

7. Do you have an allergy to any of the following?

☐ Penicillin ☐ Tape ☐ Novocaine ☐ Aspirin

☐ Cortisone ☐ Codeine ☐ Latex ☐ Antibiotics

Other allergies: _____

8. Please list any activities you participate in: _____