CLINIQUE PODIATRIQUE DE L'OUTAOUAIS

Registration questionnaire

File # : _____

Please fill this questionnaire **LEGIBLY IN BLOCK LETTERS**. All information provided will remain confidential and be used to open your file as required by the *Podiatry Act.*

Name _____ Date of birth _____/_____/_____ (YYYY MM DD)

First Name _____ Health Insurance # (RAMQ) _____

Address _____ Age _____ Sex ❑ Male ❑ Female

City _____ Height _____ Weight _____ Shoe size _____

Province _____ Postal code _____ Occupation _____

1st phone # _____ Home | Cell | Work In general, what position do you take? ❑ Sitting ❑Sstanding

2nd phone # _____ Home | Cell | Work Type of shoes ❑ Sports ❑ Dress ❑ High heel

In case of emergency (name) _____ What are your usual leisure and sports? _____

In case of emergency (phone#) _____ _____

Email address _____ Confirmation of appointment by email ❑ Yes ❑ No

Name of parents (if you are under 18 years old) _____

Who referred you to our clinic? ❑ Friends ❑ Family ❑ Television ❑ Doctor ❑ Other _____

Name of family doctor _____ Name of clinic _____

Does another professional follow you? Specify the name and profession _____

❑ Physiotherapist ❑ Chiropractor ❑ Vascular surgeon ❑ Rheumatologist ❑ Pediatrist ❑ Other _____

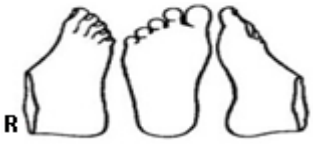
Your pharmacy _____ Phone number _____ Fax number _____

REASON FOR THE VISIT: _____

Since when? _____ Pain level from 0 to 10 Low 1 2 3 4 5 6 7 8 9 10 High

Specify where the problems are:

RIGHT FOOT



LEFT FOOT

OTHER PAINS

Ankle	❑ Left	❑ Right
Leg	❑ Left	❑ Right
Knee	❑ Left	❑ Right
Lower back.....	❑ Left	❑ Right
Sciatic nerve.....	❑ Left	❑ Right

Did you ever see a podiatrist? ❑ No ❑ Yes → How long ago? _____

Did you ever receive treatments such as ❑ Plantar orthoses? ❑ Foot care? ❑ Ingrown toenail? ❑ Foot ulcers?

MEDICAL HISTORY

1. Did you ever suffer from food allergies? ❑ YES ❑ NO
Specify allergies and type of reaction:
_____ _____

2. Did you ever suffer from drug allergies? ❑ YES ❑ NO
Specify allergies and type of reaction:
_____ _____

3. Do you take drugs or natural products? ❑ YES ❑ NO
If yes, please specify:
_____ _____
_____ _____
❑ I enclose a complete list of my medication.

4. Are you pregnant? ❑ YES ❑ NO
Due date : _____

5. Do you smoke? ❑ Tobacco ❑ Marijuana ❑ YES ❑ NO
Specify consumption per day or per week:
_____

6. Did you gain a lot of weight recently? ❑ YES ❑ NO
How much? _____ Date _____

7. Did you lose a lot of weight recently? ❑ YES ❑ NO
How much? _____ Date _____

8. Did you ever undergo surgery? ❑ YES ❑ NO
Type _____ Year _____
Type _____ Year _____
Type _____ Year _____
Type _____ Year _____

9. Do you breastfeed? ❑ YES ❑ NO

Please complete the REVERSE SIDE*

Did you ever or do you suffer from any disease or disorder?
* Please specify and indicate the year of diagnostic. *

Musculoskeletical disorders

10. Fracture (specify) : ❑ YES Year _____❑ NO
_____

11. Sprain (specify) : ❑ YES Year _____❑ NO
_____

Metobolism diseases

12. Diabetes ❑ YES Year _____ ❑ NO
❑ type 1 ❑ type 2

13. High pressure ❑ YES Year _____ ❑ NO

14. Low pressure ❑ YES Year _____ ❑ NO

15. Hypothyroidism ❑ YES Year _____ ❑ NO

16. Hyperthyroidism ❑ YES Year _____ ❑ NO

17. Osteoporosis ❑ YES Year _____ ❑ NO

18. Kidney disorder ❑ with dialysis ❑ YES Year _____ ❑ NO
Specify: _____

Rheumatological diseases

19. Rheumatoid arthritis ❑ YES Year _____ ❑ NO

20. Osteoarthritis ❑ YES Year _____ ❑ NO

21. Gout ❑ YES Year _____ ❑ NO

22. Lupus ❑ YES Year _____ ❑ NO

23. Chronic pain (specify): ❑ YES Year _____ ❑ NO
_____

24. Fibromyalgia ❑ YES Year _____ ❑ NO

25. Other arthritis types : ❑ YES Year _____ ❑ NO
_____

Neoplastic diseases

26. Cancer (specify) : ❑ YES Year _____ ❑ NO
_____

27. Leukemia ❑ YES Year _____ ❑ NO

Skin and nail disorders

28. Eczema ❑ YES Year _____ ❑ NO

29. Psoriasis ❑ YES Year _____ ❑ NO

30. Mycosis ❑ YES Year _____ ❑ NO

Genetic syndromes

31. Autism spectrum disorder ❑ YES Year _____ ❑ NO

32. Trisomy 21 ❑ YES Year _____ ❑ NO

33. Intellectual disability ❑ YES Year _____ ❑ NO

Gastrointestinal diseases

34. Gastric ulcer ❑ YES Year _____ ❑ NO

35. Crohn disease ❑ YES Year _____ ❑ NO

36. Ulcerative colitis ❑ YES Year _____ ❑ NO

Cardiovascular disorders

37. Infarction ❑ YES Year _____ ❑ NO

38. Angina ❑ YES Year _____ ❑ NO

39. Vascular problem ❑ YES Year _____ ❑ NO

40. Heart murmur ❑ YES Year _____ ❑ NO

41. Arrhythmia ❑ YES Year _____ ❑ NO

42. Venous insufficiency ❑ YES Year _____ ❑ NO

43. Phlebitis ❑ YES Year _____ ❑ NO

44. Embolism ❑ YES Year _____ ❑ NO

Neurological diseases

45. Charcot-Mary-Tooth disease ❑ YES Year _____ ❑ NO

46. Multiple sclerosis ❑ YES Year _____ ❑ NO

47. Epilepsy ❑ YES Year _____ ❑ NO

48. Stroke ❑ YES Year _____ ❑ NO

Hematological disorders

49. Anemia (specify) : ❑ YES Year _____ ❑ NO
_____

50. Hemophilia ❑ YES Year _____ ❑ NO

Psychiatric disorders

51. Depression ❑ YES Year _____ ❑ NO

52. Post-traumatic stress disorder ❑ YES Year _____ ❑ NO

53. Anxiety ❑ YES Year _____ ❑ NO

54. Psychotic disorder ❑ YES Year _____ ❑ NO

55. Bipolar disorder ❑ YES Year _____ ❑ NO

56. Other disorders (specify) : ❑ YES Year _____ ❑ NO
_____

Infectious diseases

57. Hepatitis ❑A ❑ B ❑ C ❑ YES Year _____ ❑ NO

58. HIV infection ❑ YES Year _____ ❑ NO

59. STI (sexually transmitted infections) ❑ YES Year _____ ❑ NO

Other

60. Eye disorder | blindness ❑ YES Year _____ ❑ NO

61. Hearing impairment | deafness ❑ YES Year _____ ❑ NO

62. Needle phobia ❑ YES Year _____ ❑ NO

63. Sensory disturbance ❑ YES Year _____ ❑ NO

64. Language disorder ❑ YES Year _____ ❑ NO

65. Other (specify) : _____

66. Other (specify) : _____

CONSENT AND CANCELLATION POLICY

* I consent to the exams and treatments performed by the Clinique podiatrique de l'Outaouais .

** I certify that this information is true and complete to the best of my knowledge.

*** I authorize my podiatrist to transmit and disclose my medical information to my insurance companies or my doctor (or both) if my status requires it.

**** If you cannot make it to your appointment, please let is know 24 hours in advance. Otherwise, an amount of **$25.00** will be charged.

PODIATRIC TREATEMENTS ARE NOT COVERED BY THE RAMQ.
However, your number is relevant for certain contacts with your doctor.

Signature : _____ Date : _____
(Person treated or guardian if under 14 years old)