CLINIQUE PODIATRIQUE
DE LA PETITE-PATRIE

1559 rue Bélanger
Montreal, Qc, H2B 1A9
Phone: 514-508-7433
www.mespiedsensante.com

First name: _____ Last name : _____

Adress:_____ City:_____ Zip code : _____

Date of birth: ____D/____M/_____Y Age: _____ Gender: M / F /Other:_____

Tel. (res.): _____-_____-_____ (office.): _____-_____-_____ (cell.) : _____-_____-_____

Occupation: _____Weight: _____ Height: _____ Smoker : Y / N

Email : _____ Insurance company :_____

Reason for consultation : _____ **Problem since**?_____

Shoe size:_____ Familiy doctor: _____

Do you have any allergies? If yes, which one(s)?_____

Have yo suffered from, any of the following:

- ☐ Diabetes
- ☐ Heart problem
- ☐ Veins and arteries problem
- ☐ High blood cholesterol
- ☐ Hypertension
- ☐ Gout
- ☐ Arthritis or osteoarthritis
- ☐ Liver problem
- ☐ Stomach problem
- ☐ Kidney problem
- ☐ Lung disease
- ☐ HIV
- ☐ Epilepsy
- ☐ Cancer : _____

Other:_____ If you are **pregnant** or **breastfeeding**, check here: ____

Do you take medication regularly? If yes, wich one(s) ?_____

_____

Have you ever had surgery? If yes, which one(s)?_____

_____

How did you hear about the clinic? : Facebook :___ Web site : _____Google maps :_____

Parents/friends : ____ Medical reference :_____ Other : _____

Autorization:

To the best of my knowledge, all information contained on this for is correct. I understand tha podiatric expenses are not covered by the RAMQ and I have to pay the costs incurred after the consultation. Please note that **any cancelation in the last 24 hours of you appointment may cost you 35$.**

Tutor or legal guardian (for minors) :_____

Signature: _____ Date :_____