PLEASE PRINT

Robert M Warner, D.P.M
Podiatrist - Foot Specialist
Sport Medicine

Name (first)_____ (last)_____ M ❒ F ❒

Date of Birth Month_____ Day_____ Year_____ Height_____ Weight_____

Health Card Number_____ Version Code_____

Home Address_____ Apt#_____

City_____ Postal Code_____ Occupation _____

Telephone: Home_____ Cell_____ Business_____

Family Physician _____ Telephone ( )_____

Address_____

Reason for Todays Visit:_____

MEDICAL AND PODIATRIC INFORMATION

1. Please list all allergies:_____

_____

2. Please list all drugs and medications you are taking at this time_____

_____

3. Is there any personal or Family history of Diabetes? Yes ❒ No ❒

4. Please list all illness or operations requiring hospitalization_____

_____

5. Please indicate any of the following conditions for which you have received treatment:

❒ Heart Problems	❒ Arthritis	❒ Liver Problems
❒ Asthma	❒ Gout	❒ Healing Problems
❒ Ulcers	❒ Kidney Problems	❒ Phlebitis
❒ Diabetes	❒ Anemia	❒ High / Low Blood Pressure (underline which)

6. What is your shoe size?_____

7. Are you subject to prolonged bleeding? Yes ❒ No ❒

8. Have you ever fainted in a Doctor's or Dentist's Office? Yes ❒ No ❒

9. Do you ever have leg or foot cramps? Yes ❒ No ❒

10. Do you have low back or leg pain ? Yes ❒ No ❒

11. Did your parents have any foot problems? Yes ❒ No ❒

12. Please describe any previous treatment you have had for your feet:_____

FOR OFFICE USE ONLY

❒ Doctor (Name)_____ Telephone_____

Address_____

❒ Internet ❒ Sign ❒ Yellow Pages ❒ Shoe Store ❒ Other_____

❒ Patient Name_____ Telephone_____