CHINOOK
FOOT & ANKLE CLINIC

#201 2527 Fairway Road S
Lethbridge AB
T1K 5V4, Canada
(403)-331-3338
www.chinookfoot.com

Patient Information

New Patient Information

Last Name: _____ First Name: _____
Address: _____ City: _____ Province: _____
Postal Code: _____ Phone (h): _____ (c) _____
Email: _____ Preferred Appointment Reminder: Text ☐ Email ☐
Health Care Number: _____ Sex: NB__Other__Male ☐ Female ☐ Birth Date: _____

Colony Name (if applicable): _____ Colony Phone: _____
NHIB # (if applicable): _____ K/R # (if applicable): _____

Medical Information

Family Doctor: _____ Last Date dd/mm/yyyy

Previous Podiatrist: _____ Seen: Last dd/mm/yyyy
Were you referred to this office? Y / N Date Seen:
How did you hear about the Chinook Foot and Ankle Clinic? _____

Preferred Pharmacy: _____ Pharmacy Address: _____

Have you had any of the following? Y/N

Numbness in feet	Y ☐	N ☐	Anemia	Y ☐	N ☐	Heart Disease	Y ☐	N ☐
Numbness in ankles	Y ☐	N ☐	Ulcers	Y ☐	N ☐	HIV / AIDS	Y ☐	N ☐
Liver Disease	Y ☐	N ☐	Hepatitis Kidney Disease	Y ☐	N ☐			
Varicose Veins	Y ☐	N ☐	Cramps/Swelling in feet	Y ☐	N ☐			
Arthritis:			High Blood Pressure	Y ☐	N ☐			
Osteoarthritis	Y ☐	N ☐	Diabetes	Y ☐	N ☐			
Rheumatoid	Y ☐	N ☐	Asthma	Y ☐	N ☐			

Do you have a Family History of the illness above? _____

Previous Surgeries? (Please List) _____

Pregnant or think you may be pregnant? _____ Do you smoke? Yes ☐ No ☐
Do you have any allergies to medication? (Please List): _____

Do you currently take any medication? (Please List): _____

Please describe your foot problem(s): _____

I understand all the above and hereby state that the information is correct to the best of my knowledge.

Signature: _____ Date: dd/mm/yyyy

CONFIDENTIAL DOCUMENT