MOOSE JAW PODIATRY CLINIC

300A - 99 Diefenbaker Dr.
Moose Jaw, Sask. S6J 0C2
Phone – 306-694-3338
Fax – 306-691-3608
Email – mjpodiatry@sasktel.net

DR. ATA STATIONWALA. B.SC., D.CH

Surname			**First Name**	**Date of Birth**	
Street Address			**City**	**Province**	**Postal Code**
Shoe Size	**Height**	**Weight**	**Phone Number**	**Occupation**	
Emergency Contact			**Phone Number**	**Pharmacy**	
Health Card Number			**Email**	**Family Physician**	

Describe the condition that brings you to our office today_____

_____

How long has the condition been present _____

Is this from an injury ☐Yes ☐No **If yes** ☐SGI ☐WCB

Podiatric History

Have you seen a Podiatrist before? ☐Yes ☐No

If you answered **YES**, please complete the following information.

Doctor's Name _____ Last Visited _____

Condition for which you were treated _____

Allergies **☐No Allergies**

☐Adhesive Tape	☐Latex	☐Novocaine
☐Aspirin	☐Local Anesthetics	☐Penicillin
☐Codeine	☐Iodine	☐Sea Food
☐Demerol	☐Sulfa Drugs	

Other _____

Please turn over and complete the back side of the form

Medical History

Please check off which problems you now have or have had in the past.

☐AIDS/HIV	☐Anemia	☐Arthritis	☐Artificial Heart Valve
☐Bleeding Disorder	☐Blood Clots	☐Mitral Valve Prolepses	☐Diabetes
☐Seizure or Stroke	☐Gallstones	☐Stomach Ulcers	☐Thyroid Disorders
☐Varicose Veins	☐High Cholesterol	☐Hepatitis	☐High Blood Pressure
☐Irregular Heart Beat	☐Kidney Disease	☐Gout	☐Hip/Knee Replacement
☐Neuropathy	☐Heart Attack	☐Heart Murmur	☐Asthma/Emphysema
☐Heartburn	☐Cancer	☐Psychiatric Disorders	☐Musculoskeletal Problems

Other _____

Surgeries

Please list surgeries you've had along with the date _____

_____

_____

Medications

Please list all medication including anticoagulants, contraceptive you are currently taking, including over the counter medications and vitamins_____

_____

_____

Social History

Alcohol ☐Yes ☐No How many per week_____

Smoke ☐Yes ☐No Packs per day_____

Consent

I certify that the above information is true and correct to the best of my knowledge, I give my permission to the Doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my podiatric condition(s). Payments for these services are my responsibility to be paid at the time of service provision. Receipts can be submitted to your 3rd party insurance provider.

_____ _____

Signature of Patient or Authorized Representative Date