KITSILANO Foot & Ankle Clinic
Dr. Sarah Urton, DPM
Dr. William Urton, DPM
#425-2184 West Broadway
Vancouver, BC V6K 2E1
Tel: 604-731-3431
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Patient information												
First and Last name (Legal name as on Care Card):	[please print]											
Preferred name:				Sex/gender:			Age:					
Birthdate:	Month	Day	Year	Personal Health Number:								
Address:				City:		Province:		Postal code:				
Weight:		Shoe size:	L	R	Occupation:							
Cell #:		Home phone #:			Email:							
Family Doctor:	Name:			Phone #			Fax:					
Emergency contact:	Name:			Phone #			Relationship:					

History of present illness					
What is a main problem for your appointment today?					
Which foot is involved?	Left / Right / Both				
Describe the pain:	Other:				
Sharp	Throbbing	Popping	Aching	Clicking	Tingling
Dull	Cramping	Burning	Itching	Shooting	Stabbing
When did the issue start/how long has it bothered you?					
Any other complaints which need our attention next time?					
Do you have any exams done for this problem? (X-Ray, lab results, CT scan etc.)	Where and when it was done?				
Medications:					
Allergies:					

Social history							
Do you drink alcoholic beverages?	Yes	No	How much/often?				
Do you smoke?	Yes	No	How long?		How often?		
Do you exercise?	Yes	No	How often?				

Past medical history (please check mark or circle the problem you have/had)					
Diabetes: Type 1 2;_____years	Anemia	Arthritis (Osteo / Rheum)	Back problems / Sciatica		
Blood Clot/DVT	Cancer:	Cellulitis / Skin infection (MRSA?)	Circulation problem		
Excessive / Easy bleeding	Foot / Leg ulcer	Fibromyalgia	Gout	Heart disease / Heart attack	High cholesterol
High blood pressure	Low blood pressure	Hormone therapy	Immune disorder / HIV	Kidney disease (dialysis)	
Liver disease (Hepatitis B / C / D)	Leg cramps / Leg pain at rest	Multiple sclerosis	Nervous disorder / depression		
Neuropathy	Osteomyelitis / Bone infection	Previous addiction to:			
Rashes / Skin condition	Raynaud's disease / Phenomenon	Stomach ulcers	Stroke: Rt / Lt (year ____)	Varicose veins	
Women – pregnant / breast feeding	Other problems, not listed:				
Past surgery:					

- I acknowledge the above information is correct. I understand that this information is confidential and will be used for no other purpose than for the patient's medical record. I hereby give permission for the exam, assessment, and treatment of my foot conditions by the podiatrist, Dr William Urton and Dr. Sarah Urton

- I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

- I understand the in the practise of Podiatry, as in all healthcare, there may be some slight risks of treatment. I wish to rely on the podiatrist to exercise judgement during the course exams and treatment that based on the facts known at the time, is in my best interests.

- I have read the above consent and have had the opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

Name: _____

Date: _____

Signature: _____