G.S. LINDSEY D.P.M. OFFICE FORM

Name (as on care card)	Care Card Number	Today's Date

Address	Postal Code	Phone#

Birthdate	Sex	DVA, WCB, BAND#	Referred By:

Height:	Weight:	Shoe Size:	Email (optional):

Nature of your problem:	
Previous treatment	**Onset**
IF YOU ARE UNDER THE CARE OF OTHER DOCTORS, PLEASE LIST THEIR NAMES:	

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY PF THE FOLLOWING?
PLEASE CHECK ANY THAT APPLY:

( ) ANEMIA
( ) ARTHRITIS/RHEUMATISM
( ) ASTHMA
( ) BLEEDING PROBLEMS
( ) CANCER
( ) DIABETES
( ) EPILEPSY
( ) GOUT
( ) HEART PROBLEMS
( ) HEPATITIS/LIVER DISEASE
( ) HIGH BLOOD PRESSURE
( ) HIV INFECTION
( ) KIDNEY PROBLEMS
( ) NEUROMUSCULAR PROBLEMS
( ) STOMACH ULCERS
( ) STROKE
TOBACCO ( ) PACKS/DAY _____
ALCOHOL ( ) DRINKS/WEEK _____
( ) LEG CRAMPS
( ) FOOT CRAMPS
( ) UNEQUAL LEG LENGTH
( ) KNEE PAIN
( ) TOE NAIL PROBLEMS
( ) BUNIONS
( ) LOW BACK PROBLEMS
( ) FOOT INJURIES
( ) _____

	Medications	Dose	Allergies
1			
2			
3			
4			
5			
6			

CONSENT FOR TREATMENT: I GIVE CONSENT FOR MYSELF/SON/DAUGHTER

(OR _____) TO UNDERGO EXAMINATION, LAB-WORK

Signed _____ Relationship to Patient _____