

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

BMI: \_\_\_\_\_

*\*For office use only*



# BURRARD PODIATRY

**DR. TIMOTHY P. KALLA**

**DR. ANTHONY C. YUNG**

DISORDERS OF THE FOOT

TREATMENT

SURGERY

DIABETES

**LEGAL NAME (ON CARECARD)** \_\_\_\_\_

**PREFERRED NAME** \_\_\_\_\_ **AGE** \_\_\_\_\_

**CARE CARD #:** \_\_\_\_\_ **HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **SHOE SIZE:** \_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **POSTAL CODE:** \_\_\_\_\_

**HOME PHONE#:** \_\_\_\_\_ **WORK#:** \_\_\_\_\_ **CELL#:** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

**FAMILY DR:** \_\_\_\_\_ **SPECIALIST DR:** \_\_\_\_\_

**Present Foot Problem:** \_\_\_\_\_

**Is your health usually good?** YES \_\_\_\_\_ NO \_\_\_\_\_

**Do you have prolonged bleeding after a cut?** YES \_\_\_\_\_ NO \_\_\_\_\_

**Do you smoke?** YES \_\_\_\_\_ NO \_\_\_\_\_ **If YES, how much? How long?** \_\_\_\_\_

**Do you use Alcohol?** YES \_\_\_\_\_ NO \_\_\_\_\_ **If YES, how much?** \_\_\_\_\_

**Do you have DIABETES?** YES \_\_\_\_\_ NO \_\_\_\_\_ **If YES, how long?** \_\_\_\_\_

**Daily Medications?** (Please List) \_\_\_\_\_

**Drug Allergies & Reactions?** (Please List) \_\_\_\_\_

**Have you ever had any trouble with:**

HEART \_\_\_\_\_ ASTHMA \_\_\_\_\_ LIVER \_\_\_\_\_

EYES \_\_\_\_\_ RHEUMATIC FEVER \_\_\_\_\_ STOMACH \_\_\_\_\_

ARTHRITIS \_\_\_\_\_ KIDNEYS \_\_\_\_\_ EPILEPSY \_\_\_\_\_

SLEEP APNEA \_\_\_\_\_ **IF YES, DO YOU USE A CPAP MACHINE?** \_\_\_\_\_

OTHER \_\_\_\_\_

List any past Operations: \_\_\_\_\_

**I give permission to Burrard Podiatry to confirm upcoming appointments by text or email?**

**Check One:** TEXT      EMAIL

**I give permission to Burrard Podiatry to email my medical records to myself or my delegate. I am aware that email is not secure and agree to this consent until further notice. (Initial)** \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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Our office takes all reasonable precautions to avoid the spread of communicable diseases within our office. However, there is always a risk of transmission of a communicable disease. As a result our office, including our workers and individual health care practitioners, cannot assume any liability arising from such a transmission to you or anyone else. We ask that you kindly acknowledge this risk and waive any liability on the part of our office, including our workers and individual health care practitioners, arising from the spread of a communicable disease to you or anyone else. Thank you for understanding.

**Name of Patient:** \_\_\_\_\_

(Legal Guardian if Patient under age 19)

**Signature of Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*\*If issues with submit function, please save this PDF document and email to [info@burrardpodiatry.com](mailto:info@burrardpodiatry.com) as attachment.*