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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DISORDERS OF THE FOOT TREATMENT SURGERY DIABETES

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:_____

Submit by Email

**If issues with submit function, please save this PDF document and email to info@burrardpodiatry.com as attachment.*