MEDICAL HISTORY

PATIENT NAME:_____ **AB HEALTH NO**:_____

ADDRESS:_____ **AGE**: _____
Street City Prov Postal Code

BIRTHDATE:_____**PH NO**:_____ **OTHER PH NO**:_____
Month/Day/Year

E-Mail address: for appointment reminders/newsletter:_____Decline_____

FAMILY DR: _____

THE REASON FOR YOUR VISIT TODAY:

_____

MEDICAL CONDITIONS:

_____

ALLERGIES/DRUG SENSITIVITIES:

_____

OCCUPATION: _____(This helps us understand how you use your feet)

SHOE SIZE: _____ **WEIGHT:** _____

HOW DID YOU HEAR ABOUT STEP AHEAD PODIATRY CLINICS: _____?

REFUND POLICY: There are no refunds on prescription devices and/or footwear. I have read and understand the above mentioned policies.

_____ **(Responsible Party Signature)** _____**Date**