

Dr. William Mirchoff, B.Sc., DPM
Podiatric Medicine, Biomechanics, & Surgery
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PATIENT'S NAME _____

ADDRESS _____

CITY _____ POSTAL CODE _____

PHONE: HOME _____ MOBILE _____ WORK _____

DATE OF BIRTH _____ GENDER: F M
MONTH/ DAY/ YEAR

B.C. CARECARD #

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 EMAIL _____

EXTENDED BENEFITS? ☐ YES ☐ NO IF YES, WHICH COMPANY: _____

OCCUPATION _____ SPORTS / RECREATION _____

FAMILY DOCTOR _____ REFERRED? ☐ YES ☐ NO

OTHER PERSON WHO REFERRED YOU _____

PRESENT MEDICATIONS:

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ PENICILLIN ☐ IODINE ☐ ADHESIVE TAPE OTHER _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Indicate with a check if you have had any of the following:

☐ Diabetes ☐ Insulin or ☐ Oral Control How long have you had Diabetes: _____

☐ Prolonged Bleeding / Blood Thinners ☐ Epilepsy ☐ Liver Disease

☐ Heart Trouble ☐ Arthritis ☐ Kidney Disease

☐ Thrombosis / Phlebitis ☐ Rheumatic Fever ☐ Vascular Disease

☐ High Blood Pressure ☐ Others _____

SIGNATURE _____