Thank you for selecting the Apple Wellness Center.
To help us meet all your healthcare needs,
please fill out this form completely in ink.
If you have any questions or need assistance,
please ask us and we will be happy to help.

Patient Information (confidential)

Date ______________________ (dd/mm/yyyy)

Name ______________________ Birthdate ______________ Sex : ☐ Male ☐ Female

Address ______________________ City ______________ Postal Code ______________

Phone: Res. ______________ Work ______________ Occupation ______________ PHN ______________

Marital Status: ☐ Single ☐ Married ☐ Other

Name of spouse/guardian: ______________________ Phone: ______________

Referred by: ______________________ Address: ______________________

Medical and Podiatric Information

Height: ______________ Weight: ______________ Shoe Size: ______________

Family Physician: ______________________ Address: ______________________

Last Visit: ______________________

Podiatrist: ______________________ Last Visit: ______________________

1. Are you allergic to: ☐ Novocaine ☐ Penicillin ☐ Tapes ☐ Other: ______________________
2. Are you taking medications: ☐ No ☐ Yes (specify:) ______________________
3. Have you had a serious illness or operation(s): ☐ No ☐ Yes (specify:) ______________________
4. Have you ever been treated for: ☐ high blood pressure ☐ heart problems ☐ rheumatic fever ☐ kidney problems ☐ liver problems ☐ asthma ☐ epilepsy ☐ bursitis ☐ arthritis
5. Is there a personal or family history of DIABETES: ☐ Yes ☐ No
6. Do your feet get tired towards the end of the day: ☐ Yes ☐ No
7. Do you have or have you ever had leg cramps: ☐ Yes ☐ No
8. Do you have low back pain: ☐ Yes ☐ No
9. Are you subject to prolonged bleeding after cuts or tooth extractions: ☐ Yes ☐ No
10. Do you smoke: ☐ Yes ☐ No; How much per day: ______________________
11. Do you drink alcohol: ☐ Yes ☐ No
12. Are you in good health: ☐ Yes ☐ No
13. Specify the reason for this visit: ______________________

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Signature: ______________________ Date: ______________________

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