Tammy M. Gracen, B.Sc., D.P.M.

Podiatric Medicine & Surgery

(Full Name on CareCard) *Today's Date:*_____

FULL NAME: _____ **Perferred First** Name: _____

DATE OF BIRTH : DAY _____ **MONTH**_____ **YEAR:**_____ **Email Address:** _____

Home Address : _____ City :_____ **POSTAL CODE** :_____

Telephone : _____ Marital Status : _____ Occupation : _____

Office Address : _____ Telephone :_____

Personal Health Care No. : _____ **Extended Health** : Yes _____ No _____

Name of Spouse/Guardian :_____

Address : _____ Telephone:_____

Referred to this office through : Name : _____ Telephone : +_____

MEDICAL AND PODIATRIC INFORMATION

Family Physician : _____ Telephone : _____

Office Address : _____ Fax:_____

Podiatrist : _____ Last visit : _____

Pharmacy: _____

1. **Are you allergic to : Novocaine** _____**Penicillin** _____**Sulfa Drugs** _____ **Adhesive Tapes**_____

   Others, please specify : _____

2. **Medications taken at this time** : _____

   _____

3. **Have you had any serious illness' or operation** : Yes _____ No _____

   If YES, please specify :

4. **Have you ever been treated for : High Blood Pressure** _____ **Heart Problems** _____ **Asthma** _____

   Rheumatic-Fever _____**Kidney Problems** _____**Liver Disease/Hepatitis** _____**Epilepsy** _____**Bursitis** _____

   Arthritis _____**Stomach Ulcers** _____

5. **Do you have a history of DIABETES**: Yes _____No _____

6. **Do you have any Prosthetic Joints** : Yes _____No _____

7. **Have you had an HIV (AIDS) Blood Test** : Yes _____No _____ Pos ___Neg ____

8. **Are you subject to prolong bleeding after cuts or tooth extractions** : Yes _____No _____

9. **Do you smoke** : _____ How much per day :_____

10. (Alcohol) **Drink** : _____How often: _____

11. **Are you in general good health** : Yes _____No _____

Reason for your visit: _____