The COLLEGE of PODIATRY

Medical History

Name ……

Address……

Postal Code……

Phone Home ……**Mobile**……

Email……

Date of Birth……

GP practice ……

Occupation……

Next of Kin/Emergency Contact……

Their phone number……

Medical History

Medications ……

(Prescription and ……

non-prescription) ……

Please circle yes or no to the questions below and please give further details in the space provided on the right.

Do you have or have you had any of the below:

Treated illness in last 12 months	Yes	No
Diabetes	Yes	No
Endocrine/Hormone Condition	Yes	No
History of leg/foot ulcers	Yes	No
Numbness in feet	Yes	No
Epilepsy	Yes	No
Cancer	Yes	No
Rheumatoid or Osteoarthritis	Yes	No
Heart disease/angina/heart attack	Yes	No
Pacemaker	Yes	No
High blood pressure	Yes	No
Blood clot	Yes	No
Varicose Veins	Yes	No
Peripheral Vascular Disease	Yes	No
Blood disorders	Yes	No
Abnormal bleeding after surgery	Yes	No
HIV/Hepatitis B/Hepatitis C	Yes	No
Delayed healing/sepsis	Yes	No
Previous nail/foot surgery	Yes	No
MRSA	Yes	No
Other illness/operations	Yes	No
History of fainting conditions	Yes	No
Hepatitis/jaundice/kidney disease	Yes	No
Neurological condition	Yes	No
Memory problems	Yes	No

Patient Name:

DoB:

PTO

Medical History

Skin conditions e.g. eczema, psoriasis	Yes	No
Musculoskeletal problems	Yes	No
Fractures/broken bones	Yes	No
Joint Replacements	Yes	No
Any falls in the last 6 months	Yes	No
Do you have a carer?	Yes	No
Respiratory problems eg asthma COPD	Yes	No
Do you or have you ever smoked?	Yes	No
Mental Health Diagnosis	Yes	No
Spectrum Condition	Yes	No
Genetic Condition	Yes	No
Vision Problems	Yes	No
Hearing Problems	Yes	No
Alcohol dependency	Yes	No
Drug dependency	Yes	No
Attending any GP/Hospital clinics	Yes	No
Previous Podiatry Care	Yes	No
Allergies/Sensitivities	Yes	No
Currently pregnant	Yes	No
Any other medical conditions	Yes	No

Should any of these details change in the future then please let your podiatrist know at the next appointment.

Please sign the below if you are happy to be treated by the podiatrist(s):

Patient Name:

I ……...(the patient or parent/guardian), understand and consent to being treated by a Podiatrist(s) and I confirm that I am aware that Podiatrists may use medical instruments including nail nippers, scalpel, files and burrs and I understand my data will be confidentially retained for use by Medical Personnel only.

Signed..……Date …….

Consent to medical photography, if required, of my feet and lower limbs which will be retained only on my patient file.

Signed……..Date……...

I understand that an appointment booking is a legally binding agreement and I will attend or give 24 hour's notice to change or cancel. If I fail to give 24 hour's notice to change or cancel, I understand that I will be charged an appointment fee for non-attendance.

DoB:

Signed……..Date …….

Name (PRINT)……