Stonehouse Podiatry

# Medical History Form

Personal details including a medical history are needed to provide appropriate treatment. All information collected is confidential and stored securely.
You are not obliged to provide any details, but this may affect the treatment provided. Please ask if you need assistance completing the form or have any questions.

| **Your Details** (Please Print) | |
|---|---|
| Title | First Name |
| Last name | |
| Address<br><br><br>Post Code | Telephone |
| Mobile | Email |
| Date of Birth | Occupation |
| **Your Doctors Details** | |
| General Practitioner (GP) Details of the Surgery you are registered with | |
| **Your Medical History** | |
| Please give brief details of your reason for visiting a podiatrist. | |
| | |
| Please give details of any medical treatment you have had in the last 6 months. | |
| | |
| Please give details of fractures and surgery you have had. Include any implants & joint replacements. | |
| | |
| Please list any medication you are taking including any creams you are applying. | |

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**Indicate with Yes or No and if necessary provide any other information below.**

**Do you have or have you had any of the following**

| | | | |
|---|---|---|---|
| Heart Problems | | Stroke | |
| High or Low Blood Pressure | | Asthma or other respiratory problems | |
| Rheumatic Fever | | Skin Conditions | |
| Diabetes | | Excessive Bleeding or Problems Healing | |
| Calf pain when walking | | An auto-immune condition | |
| Circulation problems in the legs or feet | | Hepatitis or Jaundice | |
| Varicose Veins | | Anaemia or hereditary blood disorders | |
| Osteo Arthritis | | Giddiness or Fainting | |
| Rheumatoid Arthritis | | Allergies | |
| Epilepsy | | COVID-19 / coronavirus infection | |

Do you smoke?
Are you pregnant?
Do you have any other medical conditions?

**PATIENT CONSENT TO CARE AND TREATMENT**

I understand that a Podiatrist will advise and treat me and may contact me to follow up on treatment.
I confirm that I am aware that Podiatrists may use sharp medical instruments.
I confirm that I have considered the risk of infection from Covid-19 and and discussed this with the podiatrist and wish to be treated.

Name

Signature Date

**MARKETING**
I consent to being contacted with marketing from Stonehouse Podiatry

Signature Date

Please do not attend for treatment if you have a high temperature and/or a new and persistent cough and/or altered sense of taste or smell.
Please do not attend for treatment within 14 days of having recovered from Corvid-19/coronavirus symptoms or being in contact with anyone you suspect of having symptoms.