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 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 prescription and non prescription medication you are taking including any creams you are applying.	

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Do you have or have you had any of the following. Please indicate with Yes or No and provide any additional information below

Diabetes	Yes / No	Hepatitis or Jaundice or Renal Disease	Yes / No
Endocrine Disorder or Condition	Yes / No	Neurological conditions	Yes / No
History of leg/foot disorders	Yes / No	Memory problems	Yes / No
Numbness in feet	Yes / No	Skin conditions eg eczema, psoriasis	Yes / No
Epilepsy	Yes / No	Muskuloskeletal problems	Yes / No
Cancer	Yes / No	Any falls in last 6 months	Yes / No
Rheumatoid Arthritis	Yes / No	Do you have a carer	Yes / No
Heart disease/angina/heart attack	Yes / No	Respiratory problems	Yes / No
Pacemaker	Yes / No	Do you or have you ever smoked	Yes / No
Rheumatic fever	Yes / No	Mental health diagnosis	Yes / No
High blood pressure	Yes / No	Spectrum disorder	Yes / No
Blood clot/varicose veins	Yes / No	Genetic condition	Yes / No
Peripheral vascular disease	Yes / No	Vision problems	Yes / No
Blood disorders	Yes / No	Alcohol dependency	Yes / No
Abnormal bleeding after surgery	Yes / No	Drug dependency	Yes / No
HIV/HepatitisB/HepatitisC	Yes / No	Attending any specialist clinics	Yes / No
Delayed healing/sepsis	Yes / No	Previous podiatry care	Yes / No
Previous nail/foot surgery	Yes / No	Allergies/sensitivities	Yes / No
MRSA	Yes / No	Currently pregnant	Yes / No
Other illness/operations	Yes / No	Any other medical conditions	Yes / No
History of fainting coditions	Yes / No		

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 including nail nippers, scalpels, files and burrs.

Signature Date