The Footcare CENTRE

PATIENT INFORMATION FORM

CONFIDENTIAL

The following details are required for your podiatry assessment

Please complete both sides of this form prior to your appointment

First Name Mr/Mrs/Miss/Ms

Surname

Date of Birth

Occupation

Home Address

Home Tel

Mob Tel

Other Tel

E-mail

Shoe Size

What is your main reason for visiting the clinic today?

What other things trouble your feet for future visits?

1.

2.

3.

Please circle any other services that may be of interest to you:

Orthotics/Laser/Ingrown Nails/Shockwave/Diabetes/Needling

General Practitioners Details

GP Name

Surgery Name

Surgery Address(if known)

How did you hear about The Footcare Centre? (please circle)
Internet / Google Friend / Family Facebook Medical referral Via NHS Passed by

Other (please Specify)

The Footcare Centre - helping you promote complete foot health. Discuss your tailored treatment program from the options below with your podiatrist

Please tick all services that are of interest to you:

General Maintenance	☐
Verrucae Treatments or Needling	☐
Biomechanical Assessments/Insoles/Orthoses	☐
Permanent Solutions for Ingrown Toenails	☐
Diabetes	☐
Low Level Laser	☐
Comfort Shoes	☐
Surgery	☐
Sports Injuries	☐
Steroid Injection	☐
Shockwave Therapy/ Painful Feet	☐
Fungal Feet & Toenails	☐

PRIVACY POLICY

Your details will be used in accordance with our patient privacy policy in connection with your medical treatment.

Should you wish to be contacted about other services or offers from The Footcare Centre please tick this box. ☐

Patient's Signature _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

The Footcare CENTRE

It is important that your Podiatrist has a clear and accurate record of your general health and history.

Please note that all information on this form will be treated in the strictest confidence and will not be shared without prior permission

Please take the time to complete the sheet below before your podiatry appointment.

Title……First Name……Surname……

MEDICATIONS (please list **all** prescribed and non prescribed medications):

- Do you take Aspirin? YES / NO
- Have you ever taken Steroids? YES / NO

DETAILS

Are you diabetic YES/NO……

If yes: For How Long……and which type……

Do you suffer from Heel Pain? YES/NO……

Do you have any history of the following?:

- Heart conditions? YES/NO……
- Stroke? YES/NO……
- Circulation problems? YES/NO……
- Breathing problems? YES/NO……
- Major Operations? YES/NO……
- Injuries or operations to the lower limb? YES/NO……
- Allergies? YES/NO……
- Major infectious diseases? YES/NO……
- (e.g. Rheumatic Fever, H.I.V, C.J.D, Hepatitis B or C, MRSA)
- Neurological problems YES/NO……
- (e.g. Polio, Neuropathy, Parkinson's, Multiple Sclerosis, Epilepsy)
- Auto immune or connective tissue disease? YES/NO……
- (e.g. SLE, Rheumatoid Arthritis, Systemic Sclerosis)
- Do you have Arthritis? YES/NO……
- Do you have any skin conditions? YES/NO……
- Could you be pregnant? YES/NO……

Please detail anything not covered:

All podiatrists are members of the Health Professions Council and have their own professional indemnity insurance in place.

I hereby consent to treatment with the podiatrist and I understand the use of sharp instruments may need be used within the appointment.

Signature

Date