The COLLEGE of PODIATRY

Kings Hill Chiropody & Podiatry

Medical History

Name …… **Address:**

DOB : ……

Medical History

Medications ……..……

(Prescription and ……..……

non-prescription)

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……

Please circle yes or no to the questions below and give further details in the space provided at the end of the form.

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

Illness in the last 6 months	Yes	No
Diabetes	Yes	No
Endocrine Disorder or Condition	Yes	No
History of leg/foot ulcers	Yes	No
Numbness in feet	Yes	No
Epilepsy	Yes	No
Cancer	Yes	No
Rheumatoid Arthritis	Yes	No
Heart disease/angina/heart attack	Yes	No
Pacemaker	Yes	No
Rheumatic fever	Yes	No
High blood pressure	Yes	No
Blood clot/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/renal disease	Yes	No
Neurological condition	Yes	No
Memory problems	Yes	No
Skin conditions e.g. eczema, psoriasis	Yes	No
Musculoskeletal problems	Yes	No
Fractures	Yes	No

Patient Name:

DoB:

The COLLEGE of PODIATRY

Kings Hill Chiropody & Podiatry

Medical History

Joint Replacements	Yes	No
Any falls in the last 6 months	Yes	No
Do you have a carer?	Yes	No
Respiratory problems	Yes	No
Do you or have you ever smoked?	Yes	No
Mental Health Diagnosis	Yes	No
Genetic Condition	Yes	No
Vision Problems	Yes	No
Hearing Problems	Yes	No
Alcohol dependency	Yes	No
Drug dependency	Yes	No
Attending any Specialist clinics	Yes	No
Previous Podiatry Care	Yes	No
Allergies/Sensitivities	Yes	No
Currently pregnant	Yes	No
Any other medical conditions	Yes	No
Confirmed Covid -19 History	Yes	No
Current Symptoms of Covid -19 Now or last 14 days	Yes	No

If you have answered Yes to any of the above please provide more detail (use the other side of the form if needed):

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Patient Name:

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

Consent to being treated by a Podiatrist(s)

I ……...(the patient), understand that I am to be seen/treated by a Podiatrist(s).

I confirm that I am aware that Podiatrists may use medical instruments including nail nippers, scalpel, files and burrs.

DoB:

Signed ……

Date ……