Patient Medical History

Section 1. Patient Details
Title……
Surname……Forenames……...
Address…….....Postcode……
Telephone – Home……..Mobile…….……Date of Birth…….
Email Address…….
Male……Female……Occupation…….
Doctors Name……..Address……..
Where did you hear about us…….....

Have you ever had or believe you have any of the following conditions?

Y	N	Condition	Details
		Diabetes	
		Thyroid problems	
		Rheumatic fever	
		Stroke or polio	
		High or low blood pressure	
		Heart complaint of any kind including heart murmurs	
		Arthritis(Osteo or Rheumatoid)	
		HIV, MRSA or contact with these conditions	
		Liver problems including hepatitis or jaundice	
		Hay fever asthma or eczema	
		Allergies to drug medicines tablets food etc	
		Implants like hip or knee pacemakers metal plates heart valves etc	
		Chest complaints including chest pain & breathing difficulties	
		Any blood disorder including anaemia or sickle cell disease	
		Any general illness in the last six months	
		Any problems with local anaesthesia	
		Fits epilepsy or blackout	

Y	N	Symptomatic	Details
		Is there a possibility that you may be pregnant	
		Have you recently gained or lost weight(other than dieting)	
		Are you excessively thirsty	
		Are you aware of any areas of numbness in your feet	
		Do you find wounds take longer to heal than they used to	
		Do you suffer from cold feet, white fingers or toes	
		Do you suffer from excessive bleeding or bruising	

Y	N	Physical Intake	Details
		Do you currently take or are prescribed any medication	
		Have you been treated with steroids or warfarin within 2 years	
		Do you smoke, if so approx. how many per day & how long	
		Have you undergone any operations in the last 2 years	
		Do you drink, if so please specify how much & how often	

Are there any other illnesses or conditions not listed above that may be relevant to your course of treatment. If so please detail below

Declaration

I declare that the information provided in this form is correct to the best of my knowledge and I give permission for Tems Chiropody and Podiatry to communicate either verbally or in writing with my GP in relation to my treatment

Signed…….....Date…….....
Name…….....

All information is stored in accordance with the Data Protection Act (1998).
As part of our ongoing commitment to improving our treatments and services to all our patients, audit and research is conducted within this clinic. For further information on how your data may be used, please contact the receptionist.