

## Medical History and Patient agreement to Podiatry Treatment

Patient's Surname ..... First name .....

Date of birth ..... Occupation .....

Address .....

Post Code .....

Tel: ..... Mobile ..... Email.....

### Consent to being treated by a Podiatrist

- I understand that I am to be seen or treated by a Podiatrist.
- I confirm that I am aware that Podiatrists may use sharp medical instruments

To be completed by the patient:

Date .....

Signed .....

Name (PRINT) .....

Parent's or guardian signature when a patient aged 17 or younger OR lack capacity to consent: Date .....

Signature ..... Name (PRINT)..... Relationship to child.....

1	Please provide name and contact number in case of emergency:	Yes/No
2	Are you on any medication (or have been in the last 6 months)? If yes, please specify.	Yes/No
3	Are you taking steroids (or have in the last 2 years)?	Yes/No
4	Any history of kidney or liver conditions?	Yes/No
5	Have you ever had trouble with your heart?	Yes/No
6	Have you ever had problems with your chest? (e.g. Asthma , COPD, other? )	Yes/No
7	Any allergies (e.g. hay fever, eczema, food, medications, dressings, latex)?	Yes/No
8	Do you suffer from high or low blood pressure?	Yes/No
9	Have you ever had Diabetes?	Yes/No
10	Do you have a Thyroid Problem?	Yes/No
11	Do you have Arthritis - Rheumatoid or Osteoarthritis	Yes/No
12	Have you ever injured or suffered from pain in the knees, hips or lower back? Which?	Yes/No
13	Do you have or have you had Epilepsy?	Yes/No
14	Do you have fainting attacks or blackouts?	Yes/No
15	Have you had surgery or recently been in hospital? (Please specify in full)	Yes/No
16	Have/had any infections such as MRSA, TB, HIV, Hep B or C, Jaundice?	Yes/No
17	Do you have any other medical conditions that we should be aware of?	Yes/No
18	Is there a history of illness in your family (e.g. heart disease, diabetes, cancer, other?)	Yes/No
19	Do you use Tobacco products?	Yes/No
20	Do you drink alcohol? How many units per week?	Yes/No
21	Do you have any eyesight or hearing difficulties? Please say which	Yes/No
22	Please state your Shoe size and your weight	Yes/No
23	Has consent to treatment been signed?	Yes/No
	Your GP name and address of surgery:	
	How did you find out about us?	