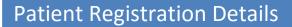
STRICTLY PRIVATE AND CONFIDENTIAL PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS





Title:	Surname:	First Name:
Address:		Date of Birth: Age:
		Tel No (Home)
		Tel No (Mobile)
Postcode		Email
Weight	Shoe Size	Smoker Yes □ No □ Quantity/ Day
Your GP's Detai	ls	
GP's Name		Tel No
Address		
Please Indicate h	now you heard about Feet in Focus pl	ease √
Existing Custom	ner □Google □ Internet □ Yell.com[🗆 Yellow Pages 🗆 Our Website 🗀 Signage 🗀 GP 🗀 BUPA
Flyers /Leaflet	☐ Consultant ☐ Physio ☐ Solicitor ☐	Other Please state name if known
ease indicate ho	ow you wish to settle your account –	Self Funding ☐ Insurance ☐ please √
for insured patients, Medical Insurer's	, please complete details) s name	Membership No.
Policy Holder's n	ame	Authorisation No.
Oncy Holder 3 III	ame	Authorisation No.
To ensure you	have been booked in for the correct	appointment please indicate the reason (s) for your visit please
V Corns ☐ Hard	d Skin 🗆 Cracked Heels 🗀 Verrucae 🗆	☐ Nail Problems ☐ Ingrown Toes ☐ Fungal Infection ☐
Joint Pain Fla	at Feet 🗆 Plantar Fasciitis 🗆 Postural	Pain 🗆 Shin Splints 🗆 Back Pain 🗀 Knee Pain 🗀 Neuroma 🗆
Other Please	e state	
Have you seen	a Chiropodist or Podiatrist before? Y	es 🗆 No 🗆
	a Chiropodist or Podiatrist before? Y	

Please turn over to complete our confidential medical questionnaire

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Medical Questionnaire



1. Do you take \underline{any} medication or tablets? Yes \square No \square (PLEASE LIST ALL)	
2. Do you have <u>any</u> allergies such as plasters, antibiotics, or anaesthetics? Yes	□ No □ (PLEASE LIST)
3. Do you have Diabetes ? Yes □ No □ Year diagnosed Average bloo	od sugar levels?
4. Have you ever had / do you have any trouble with your chest or heart? Yes	No □ (PLEASE LIST)
5. Have you had <i>any</i> hospital operations? Yes \(\subseteq\) No \(\subseteq\) (PLEASE LIST)	
6. Have you had any joint replacements, broken bones or fractures? Yes ☐ No	☐ (PLEASE LIST)
	☐ (PLEASE LIST) Yes ☐ No ☐
7. Are you pregnant? 8. Are you Asthmatic?	
7. Are you pregnant? 8. Are you Asthmatic? 9. Do you have Hepatitis?	Yes □ No □ Yes □ No □ Yes □ No □
7. Are you pregnant? 8. Are you Asthmatic? 9. Do you have Hepatitis? 10. Have you had a Stroke?	Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □
7. Are you pregnant? 8. Are you Asthmatic? 9. Do you have Hepatitis? 10. Have you had a Stroke? 11. Do you have any skin problems?	Yes □ No □
7. Are you pregnant? 8. Are you Asthmatic? 9. Do you have Hepatitis? 10. Have you had a Stroke? 11. Do you have any skin problems? 12. Do you suffer from <i>any</i> blood disorders?	Yes □ No □
7. Are you pregnant? 8. Are you Asthmatic? 9. Do you have Hepatitis? 10. Have you had a Stroke? 11. Do you have any skin problems? 12. Do you suffer from <i>any</i> blood disorders? 13. Do you have any liver or kidney problems?	Yes
7. Are you pregnant? 8. Are you Asthmatic? 9. Do you have Hepatitis? 10. Have you had a Stroke? 11. Do you have any skin problems? 12. Do you suffer from <i>any</i> blood disorders? 13. Do you have any liver or kidney problems? 14. Are you or do you have a history of epilepsy?	Yes
7. Are you pregnant? 8. Are you Asthmatic? 9. Do you have Hepatitis? 10. Have you had a Stroke? 11. Do you have any skin problems? 12. Do you suffer from <i>any</i> blood disorders? 13. Do you have any liver or kidney problems? 14. Are you or do you have a history of epilepsy? 15. Do you have any problems with rheumatism?	Yes
7. Are you pregnant? 8. Are you Asthmatic? 9. Do you have Hepatitis? 10. Have you had a Stroke? 11. Do you have any skin problems? 12. Do you suffer from <i>any</i> blood disorders? 13. Do you have any liver or kidney problems? 14. Are you or do you have a history of epilepsy? 15. Do you have any problems with rheumatism? 16. Do you have a history of back pain or sciatica?	Yes
7. Are you pregnant? 8. Are you Asthmatic? 9. Do you have Hepatitis? 10. Have you had a Stroke? 11. Do you have any skin problems? 12. Do you suffer from <i>any</i> blood disorders? 13. Do you have any liver or kidney problems? 14. Are you or do you have a history of epilepsy? 15. Do you have any problems with rheumatism? 16. Do you have a history of back pain or sciatica? 17. Do you take any Anticoagulants such as Aspirin/Warfarin?	Yes
7. Are you pregnant? 8. Are you Asthmatic? 9. Do you have Hepatitis? 10. Have you had a Stroke? 11. Do you have any skin problems? 12. Do you suffer from <i>any</i> blood disorders? 13. Do you have any liver or kidney problems? 14. Are you or do you have a history of epilepsy? 15. Do you have any problems with rheumatism? 16. Do you have a history of back pain or sciatica?	Yes
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7. Are you pregnant? 8. Are you Asthmatic? 9. Do you have Hepatitis? 10. Have you had a Stroke? 11. Do you have any skin problems? 12. Do you suffer from <i>any</i> blood disorders? 13. Do you have any liver or kidney problems? 14. Are you or do you have a history of epilepsy? 15. Do you have any problems with rheumatism? 16. Do you have a history of back pain or sciatica? 17. Do you take any Anticoagulants such as Aspirin/Warfarin?	Yes No Yes Yes No Yes Yes No Yes