STRICTLY PRIVATE AND CONFIDENTIAL

PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS

FEET IN FOCUS
PROFESSIONAL PODIATRY

Patient Registration Details

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 Details

GP's Name Tel No

Address

Please Indicate how you heard about Feet in Focus **please √**

Existing Customer ☐Google ☐ Internet ☐ Yell.com☐ Yellow Pages ☐ Our Website ☐ Signage ☐ GP ☐ BUPA

Flyers /Leaflet ☐ Consultant ☐ Physio ☐ Solicitor ☐ Other ☐ Please state name if known

Please indicate how you wish to settle your account – Self Funding ☐ Insurance ☐ **please √**

(for insured patients, please complete details)

Medical Insurer's name Membership No.

Policy Holder's name Authorisation No.

To ensure you have been booked in for the correct appointment please indicate the reason (s) for your visit **please √**

Corns ☐ Hard Skin ☐ Cracked Heels ☐ Verrucae ☐ Nail Problems ☐ Ingrown Toes ☐ Fungal Infection ☐

Joint Pain ☐ Flat Feet ☐ Plantar Fasciitis ☐ Postural Pain ☐ Shin Splints ☐ Back Pain ☐ Knee Pain ☐ Neuroma ☐

Other ☐ Please state

Have you seen a Chiropodist or Podiatrist before? Yes ☐ No ☐

Please state reason

Please turn over to complete our confidential medical questionnaire

STRICTLY PRIVATE AND CONFIDENTIAL
PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS

Medical Questionnaire

FEET IN FOCUS
PROFESSIONAL PODIATRY

We require the completion of this section to allow our Podiatrist / Chiropodist to have a full understanding of your medical history prior to your appointment. **PLEASE WRITE IN BLOCK CAPITALS AND LEGIBLY**.

1. Do you take ***any*** medication or tablets? Yes ☐No ☐ **(PLEASE LIST ALL)**

____

____

2. Do you have ***any*** allergies such as plasters, antibiotics, or anaesthetics? Yes ☐ No ☐ **(PLEASE LIST)**

____

____

3. Do you have **Diabetes**? Yes ☐ No ☐ Year diagnosed _______ Average blood 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 ***any*** hospital operations? Yes ☐ No ☐ **(PLEASE LIST)**

____

____

6. Have you had any joint replacements, broken bones or fractures? Yes ☐ No ☐ **(PLEASE LIST)**

____

____

7. Are you pregnant? Yes ☐ No ☐
8. Are you Asthmatic? Yes ☐ No ☐
9. Do you have Hepatitis? Yes ☐ No ☐
10. Have you had a Stroke? Yes ☐ No ☐
11. Do you have any skin problems? Yes ☐ No ☐
12. Do you suffer from ***any*** blood disorders? Yes ☐ No ☐
13. Do you have any liver or kidney problems? Yes ☐ No ☐
14. Are you or do you have a history of epilepsy? Yes ☐ No ☐
15. Do you have any problems with rheumatism? Yes ☐ No ☐
16. Do you have a history of back pain or sciatica? Yes ☐ No ☐
17. Do you take any Anticoagulants such as Aspirin/Warfarin? Yes ☐ No ☐
18. Is there any reason to suspect you may have HIV or have developed AIDS? Yes ☐ No ☐

I hereby consent to Podiatry/ Chiropody treatment and understand that the Podiatrist is registered with the Health & Care Professions Council. I agree to clinical pictures and video recordings to being taken to aid clinical examination and diagnosis.

Signature of patient	Signature of parent/ gaudian (Under 16 years)	Date

Medical history reviewed by ______________________ Date __________