

## 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**

## Medical Questionnaire

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)**

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

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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)**

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5. Have you had **any** hospital operations? Yes  No  **(PLEASE LIST)**

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

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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/ guardian (Under 16 years)

Date

**Medical history reviewed by**

**Date**