Medical History Form

In order for us to provide appropriate treatment, we need to know your medical history. All the information that you provide will be kept confidential. Please take your time to fill in this form. If you need help with this, let us know and we can assist you.

Personal Details (please print)

Title: Ms/ Miss/ Mrs/ Mstr/ Mr/ Dr/ First Name: _____

Surname: _____ D.O.B: _____/_____/_____

Address: _____

_____

Postcode: _____ Telephone: _____

Mobile: _____ Email: _____

How did you hear about us?: _____

Occupation: _____

General Practitioner (GP's) Details (please enter as much as possible)

Name: _____

Address: _____

Postcode: _____

Tel: _____

Medical Details

1. Is there a specific reason why you are seeing the podiatrist today? (e.g. general check-up, painful toe, corn, in-growing toe nail, joint pain, orthotics…) Please give details below:
   _____
   _____
2. Have you seen a podiatrist before? If yes, for what reason?
   _____

Have you ever had any of the following: (please tick and give details if answered 'yes'. Additional areas below can be used if more space is needed)

	Yes	No	Details
Rheumatic Fever?			
Trouble with your heart or chest?			
Pain in your chest?			
High Blood Pressure?			

Please Turn Over

	Yes	No	Details
Any Blood disorder such as anaemia or sickle cell disease?			
Difficulty Breathing?			
Pain in your legs at Rest?			
Pain in your legs when walking?			
Cold feet, white toes or fingers? (please state which one)			
Hepatitis, jaundice or problems with your liver? (please state which one)			
Fits, epilepsy or blackout? (please state which one)			
Diabetes?			
Hayfever, Asthma or Eczema? (please state which one)			
Allergies to drugs or medicines? (or an abnormal reaction to penicillin?)			
Implants like hip, knee, pacemakers or metal plates? (please give details)			
Any problems with local anaesthesia?			
Any general illness in the last six months and/or hospital treatment?			
If female, are you pregnant? (if yes, how many months?)			
Have you recently lost or gained significant weight? (please circle and give approximate weight loss/gain?			
Are you aware of any numbness in your feet?			
Do you have any problems with healing (e.g. if you cut or bruise yourself)			
Do you smoke? (if yes, how many per day?)			
Do you take aspirin regularly?			

Please include further details here:

_____

3. Are you taking any medication? (including creams, drops, inhalers etc.) if yes, please state:

_____

_____

_____

_____

Thank you for your time in filling out this form. Should any of the above details change whilst you are a patient at Kent Foot & Ankle Clinic, please remember to inform the podiatrist.

Please Tick Box If You Do Not Wish To Receive Information On Offers/ Promotions/ Advice/ Tips & Health Awareness ☐

I certify that the above information is correct to the best of my knowledge and will inform Kent Foot & Ankle Clinic of any changes.

Print Name: _____ Date: _____

Patient Signature (or parent/guardian): _____