

**CONFIDENTIAL
PATIENT DETAILS**

Surname		Title
First Name(s)		
Date of Birth		
Address (with Postcode)		
Home Telephone		
Mobile Telephone		
Email		
GP's Name & Surgery Address		

SIGNED CONSENT TO TREATMENT & THE PROPER USE OF YOUR DATA:

TREATMENT: Podiatry treatments may involve the use of sharp, sterile instruments. This carries a small risk of bleeding and post-operative infection. You are advised to follow any guidance with regard to wound care and follow-up appointments. Failure to do so may cause worsening or non- resolution of symptoms. We follow guidelines set by The Royal College of Podiatry.

DATA: As outlined in our *Data Protection & Privacy Policy*

Signed and dated by Patient / Parent / Guardian:

Signed and dated by Podiatrist:

Please PRINT name

Full Name:		Title
Please list all your current prescribed and nonprescribed medication		
Are you diabetic?	YES NO	Which Type? When diagnosed?

MEDICAL HISTORY: IF 'YES', PLEASE GIVE DETAILS...

Do you have any Heart Conditions?	YES	NO
Circulation Problems	YES	NO
Breathing Problems	YES	NO
Are you receiving, or have you received, treatment for any form of cancer?	YES	NO
Major Infectious Diseases (e.g. Rheumatic Fever, HIV, CJD, Hepatitis or MRSA)	YES	NO
Neurological Problems (e.g. Stroke or TIA, Polio, Parkinson's, MS, Epilepsy, Neuropathy)	YES	NO
Auto Immune or Connective Tissue Disease (e.g. SLE, Rheumatoid Arthritis, Systemic Sclerosis)	YES	NO
Arthritis	YES	NO
Skin Conditions	YES	NO
Major Surgery	YES	NO
Injuries or Operations to Legs and Feet	YES	NO
Allergies	YES	NO
Are you pregnant or breast feeding?	N/A	YES NO

Signed and dated by Patient / Parent / Guardian:

Signed and dated by Podiatrist:

Please PRINT name