CONFIDENTIAL MEDICAL HISTORY FORM

In order to carry out a complete assessment, we require you to complete the following form. Any medical information may be relevant and influence the proposed management of your feet and as such a number of questions are asked about the whole of the body (including medications).

ACCESS TO YOUR RECORDS

You have the right of access to the data that we hold about you and to receive a copy. Parents may access their child's records if this is in the child's best interests and not contrary to a competent child's wishes. Formal applications for access must be in writing to Lucy Rutler.

IF YOU DO NOT AGREE

If you do not wish personal data that we hold about you to be disclosed or used in the way that is described in this Code of Practice, please discuss the matter with your podiatrist. You have the right to object; however, this may affect our ability to provide you with Podiatry care. You have a right to withdraw your consent at any time.

SECURITY OF INFORMATION

Personal data about you is held on a password protected cloud based clinical software system. Medical information can only be accessed by the treating Podiatrist.

WHY DO WE HOLD INFORMATION ABOUT YOU?

We need to keep comprehensive and accurate personal data about patients to provide you with safe and appropriate Podiatry care. We will ask you yearly to update your medical history and contact details.

WHAT PERSONAL DATA DO WE HOLD?

To provide patients with a high standard of podiatry care and attention, we need to hold the following personal information including:

- Past and current medication conditions; personal details such as age, address, telephone number and general medical practitioner
- Clinical photographs and videos (these are stored on your patient records and used for clinical purposes only)
- Information about treatment provided, its purpose and cost
- Notes of conversations or incidents that might occur for which a record needs to be kept
- Records of consent to treatment
- Correspondence with other health care professionals relating to patients.

The information you complete on this form will not be shared with any outside agencies (with the exception of referrals and any reports required in relation to your care, which the Podiatrist will ask for your consent before proceeding) and will be kept in a secure location on the premises.

If you have any questions or concerns about the information you are asked about, please feel free to discuss this with the Podiatrist.

PERSONAL DETAILS

PERSONAL INFORMATION ☐ **PLEASE TICK IF UNDER 16 YEARS OLD**

TITLE .... FORENAME(S) ....

SURNAME .... DATE OF BIRTH ....

SEX .... OCCUPATION ....

ADDRESS ....

.... POSTCODE ....

CONTACT DETAILS

HOME .... MOBILE ....

WORK .... EMAIL ....

NEXT OF KIN

NAME .... RELATIONSHIP TO YOU ....

TELEPHONE ....

GP CONTACT INFORMATION

NAME OF YOUR GP ....

SURGERY ADDRESS ....

....

SURGERY TELEPHONE ....

MEDICAL HISTORY

Do you have or have you had any of the below? If so, please give further details in the space provided at the end of the form.

- [ ] Type 1 Diabetes. Year diagnosed ________
- [ ] Type 2 Diabetes. Year diagnosed ________
- [ ] Illness in the last 6 months
- [ ] Endocrine Disorder or Condition
- [ ] History of leg/foot ulcers
- [ ] Numbness in feet
- [ ] Epilepsy
- [ ] Cancer
- [ ] Heart disease/ angina/ heart attack
- [ ] Pacemaker
- [ ] High blood pressure
- [ ] Blood clot/ varicose veins
- [ ] Stroke or TIA
- [ ] Low blood pressure
- [ ] Blood disorders
- [ ] HIV/AIDS/ Hepatitis B/ Hepatitis C
- [ ] Peripheral Vascular Disease
- [ ] Abnormal bleeding after surgery
- [ ] Delayed healing/sepsis
- [ ] Previous nail/foot surgery
- [ ] MRSA
- [ ] Other illness/ operations
- [ ] History of fainting conditions
- [ ] Hepatitis/jaundice/renal disease
- [ ] Neurological condition
- [ ] Memory problems
- [ ] Skin conditions e.g. eczema, psoriasis
- [ ] Musculoskeletal problems
- [ ] Fractures
- [ ] Joint Replacements
- [ ] Any falls in the last 6 months
- [ ] Osteoarthritis
- [ ] Inflammatory arthritis e.g. rheumatoid, psoriatic, SLE
- [ ] Rheumatic fever
- [ ] Back ache/ disc problems
- [ ] Stomach ulcer/ dyspepsia
- [ ] Do you have a carer?
- [ ] Respiratory problems
- [ ] Do you smoke? No. per day ________
- [ ] Have you ever smoked? No. per day ________
- [ ] Blood disorders
- [ ] Mental Health Diagnosis
- [ ] Spectrum Condition
- [ ] Genetic Condition
- [ ] Vision Problems
- [ ] Hearing Problems
- [ ] Do you drink alcohol? Units per week ________
- [ ] Do you take recreational drugs?
- [ ] Attending any Specialist clinics
- [ ] Previous Podiatry Care
- [ ] Allergies/Sensitivities
- [ ] Currently pregnant
- [ ] Any other medical conditions

Further Details:

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PODIATRY QUESTIONNAIRE

Please list any sports/ activities in which you participate, at what level (professional/elite, amateur, hobby) and how frequently? (times per week/month/year)

Does your occupation involve periods of standing or walking?

Please list all medications taken (please include any herbal, complementary medication, vitamins, supplements and over the counter medicines or preparations).
PLEASE INCLUDE DOSE AND FREQUENCY

Please describe your current problem/ complaint:

Shoe Size:

Marketing - please could you let us know how you heard about us?:

Please sign and date the below if you are happy to be treated by the Podiatrist(s):

Consent to being treated by a Podiatrist(s)

I (the patient), understand that I am to be seen/treated by a Podiatrist(s). I confirm that I am aware that Podiatrists may use medical instruments including nail nippers, scalpel, files and burrs.

Data protection: I permit you to hold this form and my clinic records electronically in accordance with GDPR (General Data Protection Regulations). I understand that the information will be kept confidential and not shared with any third parties unless prior consent has been issued (this may be verbal and indicated as such in the patient records or written/signed for as appropriate).

Patient/parent/guardian signature **Date**