

CONFIDENTIAL MEDICAL HISTORY AND PATIENT CONSENT 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 annually 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 present medical conditions and medications; 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

TITLE FORENAME(S)

SURNAME DATE OF BIRTH

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 this section.

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

Further Details:

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?:

CONSENT

Consent to being treated by a Podiatrist(s)

I understand that I am to be seen/treated by a Podiatrist. I confirm that I am aware that Podiatrists may use sharp medical instruments.

I confirm that I am aware there is currently a Covid-19 pandemic and by being treated there is a small risk of transmission due to mixing with other people. The podiatrist will wear appropriate protective equipment and follow strict infection control protocols to minimise the risk as much as they can. I therefore consent to treatment with this knowledge.

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 signature _____

Date _____