Welcome

New patient registration

Queensferry Podiatry

In order for us to provide appropriate treatment, we need to know your medical history. All the information you provide will be kept confidential. If you need help with filling this form out, let us know and we can assist you. Welcome to Queensferry Podiatry.

Patient Information

Title: Mr / Mrs / Miss / Ms / Dr	First Name:	Surname:
Address: Post Code:		Date of Birth:
Home Telephone No:	Mobile No:	
Email Address:		
GP Name and Practice:		
Medical Insurance Details (if applicable):	Policy number:	

Medical History

	Please circle		Details
Illness in the last 6 months	Yes	No	
Diabetes	Yes	No	
Endocrine disorder e.g. thyroid disease	Yes	No	
History of leg/foot ulcers	Yes	No	
Numbness in feet	Yes	No	
Epilepsy	Yes	No	
Cancer	Yes	No	
Rheumatoid arthritis	Yes	No	
Heart disease / angina / heart attack	Yes	No	
Pacemaker	Yes	No	
Rheumatic fever	Yes	No	
High blood pressure	Yes	No	
Blood clot / varicose veins	Yes	No	
Peripheral vascular disease	Yes	No	
Blood disorders, such as anaemia	Yes	No	
Abnormal bleeding after surgery	Yes	No	
HIV / hepatitis B / hepatitis C	Yes	No	
Jaundice / renal disease	Yes	No	

Please turn over.

New patient registration

	Please circle		Details
Delayed healing / sepsis	Yes	No	
Previous nail / foot surgery	Yes	No	
MRSA	Yes	No	
Healing problems / infections	Yes	No	
Neurological condition	Yes	No	
Memory problems	Yes	No	
Skin conditions e.g. eczema / psoriasis	Yes	No	
Fractures	Yes	No	
Joint replacements	Yes	No	
Any falls in the last 6 months?	Yes	No	
Do you have a carer?	Yes	No	
Respiratory problems	Yes	No	
Do you or have your ever smoked?	Yes	No	
Vision or hearing problems?	Yes	No	
Allergies / sensitivities	Yes	No	
Any other medical conditions?	Yes	No	
Are you taking any medication? If so, please state.			
Reason for podiatry treatment:			

Consent to being treated by a Podiatrist

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 including nail nippers, scalpel, files and burrs.

In the case of a missed appointment or late cancellation (less than 24 hours), you will be charged a full fee missed appointment charge.

Signed: (Patient/Persons with parental/legal responsibility):

Relationship to patient (if applicable):

Date:

How did you hear about us? (Please circle)

Recommendation / GP / Local knowledge / Advertisement / Internet / Other _____

For official use only. Completed by (please circle):

Patient / Podiatrist / Receptionist / Other _____