foot • knee • back
clinic

# Patient Medical History Form

| | |
|---|---|
| **Title Surname** | **Male / Female** |
| **Forenames** | **Occupation** |
| **Date of Birth** | |
| **Address** | **Doctors Name** |
| | **Address** |
| | |
| **Postcode** | |
| **Telephone Mobile** | |
| **Home** | |
| **Email Address** | |

Where did you hear about us? _____

**Have you ever had or believe you have any of the following conditions?**

| Y | N | Condition | Details |
|---|---|---|---|
| | | Arthritis (Osteo or Rheumatoid) | |
| | | Anaemia (including sickle cell or thalassemia) | |
| | | Asthma or COPD | |
| | | Diabetes | |
| | | Epilepsy | |
| | | High blood pressure | |
| | | Heart complaint (including previous heart attack or heart murmurs) | |
| | | Skin condition | |
| | | Have you had a Stroke or TIA? | |
| | | Rheumatic fever | |
| | | Thyroid problems | |
| | | Liver problems including hepatitis or jaundice | |

| Y | N | | |
|---|---|---|---|
| | | Do you have a pacemaker? | |
| | | Have you had a heart valve replacement? | |
| | | Do you have any implants in your body (including screws/ plates) | |
| | | Any general illness in the last six months | |
| | | Any problems with local anaesthesia | |

| Y | N | | |
|---|---|---|---|
| | | **Ladies:** Is there a possibility that you may be pregnant? | |
| | | Are you aware of any areas of numbness in your feet? | |
| | | Do you find wounds take longer to heal than they used to? | |
| | | Do you suffer from cold feet, white fingers or toes? | |
| | | Do you suffer from excessive bleeding or bruising? | |

| Y | N | | |
|---|---|---|---|
| | | Do you currently take or are prescribed any medication? **Please list these or attach a copy of your prescription.** | |
| | | Have you been treated with steroids or warfarin within 2 years? | |
| | | Do you smoke, if so approx. how many per day & how long? | |
| | | Have you undergone any operations in the last 2 years? | |
| | | Do you drink alcohol, if so please specify how much & how often? | |

**Are there any other illnesses or conditions not listed above that may be relevant to your course of treatment? If so please detail below (or use this box to list medication if necessary)**

**Declaration**

- **I declare that the information provided in this form is correct to the best of my knowledge.**
- **I give permission for the Long Eaton Foot, Knee and Back Clinic to communicate either verbally or in writing with my GP in relation to my treatment should this be necessary.**

**Signed**_____**Date**_____

**Print Name**_____

**All information is stored in accordance with the Data Protection Act (1998).**
**As part of our ongoing commitment to improving our treatments and services to all our patients, audit and research is conducted within this clinic. For further information on how your data may be used, please contact the receptionist.**