



MEDICAL QUESTIONNAIRE

These details must be completed as a minimum prior to an appointment

Foot Care

We require the completion of this section to allow our professional team to have a full understanding of your medical history prior to your initial appointment. Answers that you provide in this section will remain confidential.

Please tick all boxes relevant to you.

Are You?

Likely to be pregnant Taking steroids (or have in the last 2 years)

Have you ever had?

Rheumatic Fever A bad reaction to local/general anaesthetic
Jaundice Hospital operation
Hepatitis Joint replacement
Trouble with your heart or chest

Details

Do You?

Suffer from any allergies Have fainting attacks/blackouts
Suffer from blood disorders Have diabetes
Are you taking any medication (if so state below)

Signature

Date



PATIENT QUESTIONNAIRE

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First Names	<input type="text"/>	Introduced by	<input type="text"/>
Surname	<input type="text"/>	Previous Name	<input type="text"/>
Title	<input type="text"/>		
Male/Female	<input type="text"/>	Date of birth	<input type="text"/>

Home Address

Street	<input type="text"/>
	<input type="text"/>
City	<input type="text"/>
Post Code	<input type="text"/>
Home Tel	<input type="text"/>
Work Tel	<input type="text"/>
Mobile	<input type="text"/>
Email	<input type="text"/>

Work Details

Occupation	<input type="text"/>
Employer	<input type="text"/>
Address	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
Post Code	<input type="text"/>

Doctors Details

Name	<input type="text"/>	Surgery	<input type="text"/>
Telephone	<input type="text"/>	Post Code	<input type="text"/>

Please ALWAYS update your chiropodist on any changes. Thank you for completing the questionnaire.