PRIME PODIATRY

PATIENT INFORMATION SHEET

Please print neatly and clearly

Mr Mrs Miss Ms Dr Date of Birth _____

Surname _____ First Name _____

Address _____

_____ Post Code _____

Telephone Home _____ Mobile _____

Work _____ Occupation _____

Email _____

Private Health Fund _____ Health Care Card/Pension Y / N

Doctor _____

Address _____

Who referred you to this clinic? _____

Next of kin _____ Telephone _____

Medical Details: Have you ever had any of the following?

❑ Asthma	❑ High Blood Pressure	❑ Low Blood Pressure
❑ Diabetes	❑ Heart disease	❑ Gout
❑ Hepatitis	❑ Epilepsy	❑ Slow/poor healing
❑ Blood borne viruses	❑ AIDS	❑ Blood clotting
❑ Skin conditions	❑ Stroke	❑ Osteoarthritis
❑ Allergies	❑ Anaemia	❑ Rheumatoid arthritis

Other: _____

_____

Medications _____

_____

_____

History of lower limb surgery _____

_____

Reason for this visit _____

_____

How long have you had this complaint? ___Days ___Months ___Years

Sports you engage in _____