**PATIENT RECORDS** Date of Initial Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Details:** Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Likes Dogs: YES/NO

|  |  |
| --- | --- |
| **Name:** | **DOB:** |
| **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Postcode:** | Confirmation of Appointment Email/Letter Date Sent: / / 1st/2nd/Text/By HandTime:  |
|

|  |
| --- |
| **Home Telephone No:** |
| **Work Telephone No:** |
| **Mobile Telephone No:** |

 |

|  |
| --- |
| **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| E. Trash | Directions | Cash/BT | Other |
|  |  |  |  |

 |

**Emergency Contact Details:**

|  |  |
| --- | --- |
| **Name:** | **Relationship:** |
| **Address:** ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Telephone:** | **Mobile:** |

**Medical Details:**

|  |  |
| --- | --- |
| **Doctor:** | **Telephone:** |
| **Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Other Care Providers:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Medical Conditions:**

|  |  |  |
| --- | --- | --- |
| **Condition:** | **Date of Diagnosis:****(Approximate)** | **Treatment/Medication:** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Cancer/Skin Cancer:** Y/N |  |  |
| **Memory Problems:** Y/N |  |  |

**Mobility: (Slope & 1 step into house)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Unaided:** | **With Walking Aids:** | **Unable to Weight Bear:** | **Confined to Bed:** |

**Status:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Spouse/Family:** | **Alone:** | **Residential:** | **Attends D/Care Facility:** |

**Allergies:**

|  |
| --- |
|  |
|  |

**Patients Concerns:**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

**Patient Consent:**

I agree to allow Carol M Sedgwick in her duty as a Podiatrist to treat me today and all subsequent treatments. I give her authorisation, if necessary, to contact a third party in relation to my treatment and physical/mental health (a family member &/or Doctor).

**Please be aware that you are liable for 50% of the full fee if you fail to attend your appointment OR if you fail to give a cancellation notice of 24 hours’.**

**I agree to treatment whilst there is a risk of contracting COVID 19.**

**Patients/Guardians Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Carol M Sedgwick: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find out about my business? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information**: **Shoe Size:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| TestsDate: | Temperature& Colour | Capillary Refill(Seconds) | Pulse (Present) | 128Hz Fork (Present) | 10mg Monofilament(Present) |
| Left Foot |  |  |

|  |  |
| --- | --- |
| DP |  |
| PT |  |

 |

|  |  |
| --- | --- |
| 1Apex |  |
| 1MPhJt |  |
| M.Malleolar |  |

 |

|  |  |  |  |
| --- | --- | --- | --- |
| 1A |  | 3A |  |
| 5A |  | PMA1 |  |
| PMA5 |  | Calc |  |

 |
| Right Foot |  |  |

|  |  |
| --- | --- |
| DP |  |
| PT |  |

 |

|  |  |
| --- | --- |
| 1Apex |  |
| 1MPhJt |  |
| M.Malleolar |  |

 |

|  |  |  |  |
| --- | --- | --- | --- |
| 1A |  | 3A |  |
| 5A |  | PMA1 |  |
| PMA5 |  | Calc |  |

 |

|  |  |
| --- | --- |
| Date & Time of Treatment | Patient Notes: |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |