**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 Hand  Time: |
| |  | | --- | | **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:**

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| --- | --- | --- |
| **Condition:** | **Date of Diagnosis:**  **(Approximate)** | **Treatment/Medication:** |
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| **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:**

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**Patients Concerns:**

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**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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- |
| Tests  Date: | 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 |  | |

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