# SURE FOOT PODIATRY

## NEW PATIENT FORM

Name

Year 20

Thank you for booking your podiatry appointment. We would like to ask you some KEY information before we begin your treatment.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ DR ☐ Rev        Date of Birth (      /      /      )

Name ..................................................        Telephone ...............................................

Address ..........................................................................................................................

..........................................................................        Post Code ...............................

Doctor's Surgery ..................................................................        Shoe Size ...............

What is the main issue which you have come with? .........................................................

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How did you find out about our service? ..........................................................................

## Your health and medical history

Do you have a history of any of the following? (please tick)

☐ Diabetes
☐ Taking steroids
☐ Hepatitis (A,B, or C)
☐ Epilepsy, fainting or anxiety attacks
☐ Taking warfarin
☐ MRSA infection
☐ HIV/Aids
☐ Known allergies-please state

Do you have any other medical conditions? ......................................................................

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Do you take any regular medicines? (please list) ..............................................................

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Have had any surgical procedures? (please list) ...............................................................

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## Vascular Findings

| | Absent | Present | Doppler Result | Comments |
|---|---|---|---|---|
| Right Dorsalis Pedis | | | | |
| Right Posterior Tibial | | | | |
| Left Dorsalis Pedis | | | | |
| Left Posterior Tibial | | | | |

Does the patient report intermittent claudication?

☐ Yes ☐ No Comments:

## Neurological Findings

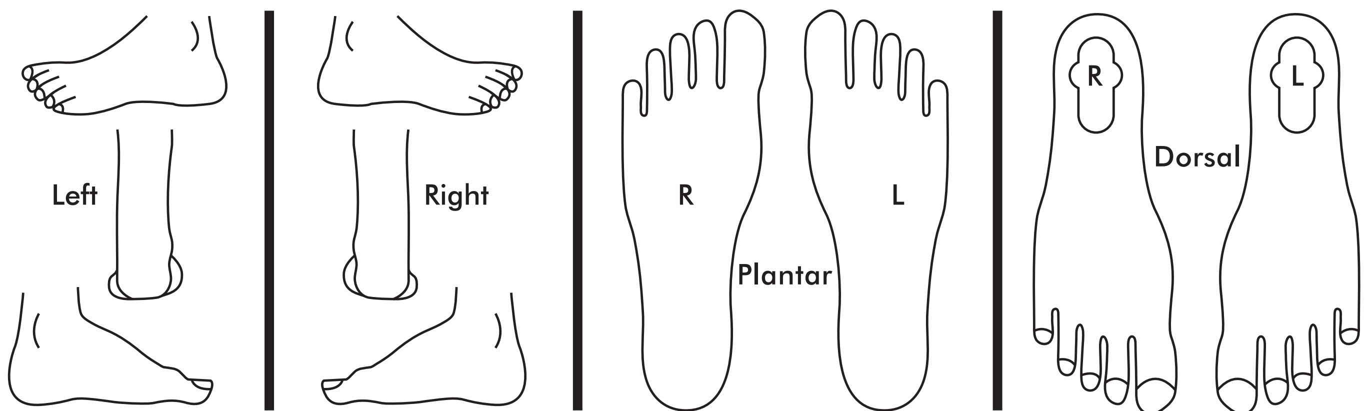
| | Sensation Detected – 10g monofilament | Vibration Detected – tuning fork |
|---|---|---|
| Right Foot | /10 | /10 |
| Left Foot | /10 | /10 |

Did the patient report any other sensation issue i.e. burning, painful neuropathy?

☐ Yes ☐ No Comments:

## Key Pathologies (eg structure, function, dermatology)

## Lesions




## Treatment Plan

**Consent** - **I agree to treatment as discussed.**

Name ................................................ Signature ......................................... Date ..................

Podiatrist Signature ......................................... Date ..................