THE
FOOT & GAIT CLINIC

Medical History Form

Please complete this form with the most up to date information. If you require help reading this form, please do ask our reception team, and they will happily help you. If anything changes please let us know, so we can update our records.

Patient Name: _____ Date of Birth: _____

Medications:

THE
FOOT & GAIT CLINIC

Please circle yes or no to the questions below and give further details in the space provided at the end of the form.

Do you have or have you had any of the below:

Illness in the last 6 months	Yes	No
Diabetes	Yes	No
Thyroid Disorder or Condition	Yes	No
History of leg/foot ulcers	Yes	No
Cancer	Yes	No
Rheumatoid Arthritis	Yes	No
Heart Disease/Stroke/Heart Attack	Yes	No
Pacemaker	Yes	No
Rheumatic Fever	Yes	No
High Blood Pressure	Yes	No
Blood Clot/Varicose Veins	Yes	No
Circulatory problems	Yes	No
Blood Disorders	Yes	No
Abnormal Bleeding	Yes	No
HIV/Hepatitis B/Hepatitis C	Yes	No
Delayed Healing	Yes	No
Previous Nail/Foot Surgery	Yes	No
MRSA	Yes	No
Operations	Yes	No
History of Fainting	Yes	No
Liver Disease (e.g. jaundice)	Yes	No
Neurological Conditions (eg epilepsy - Parkinsons and MS)	Yes	No
Kidney Problems	Yes	No
Memory Problems	Yes	No
Skin Conditions e.g. Eczema, Psoriasis	Yes	No
Musculoskeletal Problems	Yes	No
Fractures	Yes	No
Joint Replacements	Yes	No
Any Falls in the last 6 months?	Yes	No
Do you have a carer?	Yes	No
Breathing Problems	Yes	No
Do you or have you ever smoked?	Yes	No

THE
FOOT & GAIT CLINIC

Mental Health Problems	Yes	No
Genetic Condition	Yes	No
Vision Problems	Yes	No
Hearing Problems	Yes	No
Alcohol Dependency	Yes	No
Drug Dependency	Yes	No
Attending any Specialist clinics?	Yes	No
Have you had any previous foot Care?	Yes	No
Allergies/Sensitivities	Yes	No
Are you currently pregnant?	Yes	No
Do you have any other medical conditions?	Yes	No

If you have answered Yes to any of the above please provide more detail (use the other side of the form if needed):

_____

_____

_____

_____

_____

Signed _____

Date _____