Torbay and South Devon NHS Foundation Trust

PATIENT INFORMATION

Podiatry

Annual Review Questionnaire

NAME:	DATE OF BIRTH:	NHS NUMBER:	ICS NUMBER:
PREFERRED NAME:		**ETHNICITY:**	

Every 12 months we like to undertake a review of our patients' medical history. To ensure that your medical history is up to date, please complete answer the questions below and bring this form with you to your appointment.

Are you a diabetic?		**YES**		**NO**	
If diabetic latest HbA1c		**DATE**			
Have you any allergies?		**YES**		**NO**	
If yes, please give details:					
Next of Kin/Person to contact in an emergency					
Telephone number:					
If in a wheelchair, can you transfer onto a treatment couch?		**YES**		**NO**	

In the last 12 months, have you developed any of the following?

Condition		If YES, please give details
Any heart problems, e.g. angina, irregular heartbeat, heart attack?	YES / NO	
Any neurological problems e.g. stroke, Parkinson's, Multiple Sclerosis?	YES / NO	
Any breathing problems e.g. asthma, COPD?	YES / NO	
Any kidney or liver problems?	YES / NO	

Any skin problems e.g. eczema?	YES / NO	
Any eye problems, e.g. cataract, macular degeneration?	YES / NO	
Any infectious disorders, e.g. MRSA, hepatitis?	YES / NO	
Any circulatory problems, e.g. varicose veins, ulceration, blocked arteries.	YES / NO	
Condition		**If YES, please give details**
Any inflammatory arthropathies, e.g. Rheumatoid arthritis, ankylosing Spondylitis?	YES / NO	
Have you had any operations?	YES / NO	
Is there anything else in your medical history that has changed that you think we should be aware of?	YES / NO	
Please list any medication you are taking		

The information I have provided on this form is, to the best of my knowledge, accurate.	YES / NO
I consent to photographs being taken of any foot problems where it is relevant or may enhance my care.	YES / NO
The Podiatry Department have students from the University of Plymouth on placement. I consent to **observation/treatment** under supervision by a podiatry student (please delete if consent to one element is not given).	YES / NO
I understand that the information provided is confidential. However, I agree that this information may be shared with health and social care professionals, and service providers who contribute to my care.	YES / NO
I understand that I may withdraw or restrict my consent to share information at any time and this may result in a reduction of services being available.	YES / NO
I consent to having podiatry treatment when I attend for my appointment and understand that I may withdraw or restrict my consent to treatment at any time. *For some procedures, e.g. nail surgery, you will be asked to complete a separate consent form.*	YES / NO
ANY PERMISSION GIVEN IS VALID FOR A 12 MONTH PERIOD BUT CAN BE WITHDRAWN AT ANY TIME AT THE PATIENT'S REQUEST.	

NAME	**SIGNATURE**	**DATE**

For further assistance or to receive this information in a different format, please contact the department which created it.