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**Medical History**

**All details and strictly confidential to the practice and comply with General Data Protection**

[ ]  **Mary Fenner MSSch MBchA** [ ]  **Nikki Spiers S.A.C Dip RFHP** [ ]  **Sue Irvine MCFHP MAFHP**

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| --- | --- |
| **Full Name:** |  |
| **Address:** |  |
| **Date of Birth:** |  |
| **Email Address:** |  |
| **Phone Number:** |  |
| **Occupation:** |  |
| **Name and Address of Medical Practitioner:** |  |

We would like to use your contact details to assist with the administration of your appointments, changes to scheduled appointments and send reminders about upcoming appointments.

[ ]  I consent [ ]  I do not consent

Have you ever suffered from Rheumatic fever? [ ]  Yes [ ]  No

Have you ever suffered from Epilepsy? [ ]  Yes [ ]  No

Have you ever suffered from chronic bronchitis/asthma? [ ]  Yes [ ]  No

Have you ever suffered from high or low blood pressure?

[ ]  High blood pressure [ ]  Low blood pressure [ ]  No

Are you diabetic? [ ]  Type 1 [ ]  Type 2 [ ]  No

Do you take Warfarin/Aspirin or any blood thinning tablets? [ ]  Yes [ ]  No

If yes, what are these?

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Do you suffer with Arthritis? [ ]  Yes [ ]  No

Do you suffer from any heart problems? [ ]  Yes [ ]  No

If yes, please can you provide more detail.

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Do you have any known allergies? [ ]  Yes [ ]  No

If yes, please can you provide more detail.

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Do you have any known skin conditions? [ ]  Yes [ ]  No

If yes, please can you provide more detail.

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Have you had any joint replacements? [ ]  Yes [ ]  No

If yes, please can you provide more detail.

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|  |

Please list any medication you are currently taking.

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Please list any other information you feel we should know before your treatment.

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**Cancellation Policy**

Appointments cancelled within 24 hours and no-shows will incur a full fee.

**Consent Declaration**

By signing below, you are providing your consent to be treated at Simply Feet and understand that:

* No treatment will be offered or undertaken without a full explanation of the range of options available to you and the expected outcome of these treatments
* Any risks will be outlined, and questions answered to the best of our ability
* Any aftercare advice needs to be followed to ensure effective results from treatment in between appointments

We may ask to photograph your feet at any time for informative purposes. Your identity will not be disclosed.

**Data Protection Policy**

Your personal medical details will be kept in accordance with the General Data Protection

Regulations of May 2018. Your medical history and personal details will be kept securely and

confidentially for a minimum of 7 years after your last appointment with us.

Please note, if you do not consent, we will be unable to carry out assessment or treatment.

**By signing you consent to the above.**

Please sign inside the box: Date:

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