**Patient Medical History**

**Clinician name:**

**Clinic name:**

**Clinic Address:**

**Clinic contact details:**

**All information on this form will be kept confidential. To ensure you receive the appropriate treatment for you, the form should be completed accurately. If you need any assistance completing this form, please ask.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname:** |  | **Title:** | Mr / Mrs / Ms / Miss /  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Forename(s):** |  | **Date of Birth:** | / / |
| **Telephone:** |  | | |
| **Email:** |  | | |
| **Address:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Name and address of GP** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode:\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **GP Telephone:** |  | | |

**Medical History**

**Have you ever had any of the following: (please tick and give details if answered ‘yes’)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Details |
| Do you take aspirin regularly? |  |  |  |
| Are you aware of any numbness in your feet? |  |  |  |
| Pain in your legs when resting? |  |  |  |
| Pain in your legs whilst walking? |  |  |  |
| Diabetes? |  |  |  |
| Difficulty breathing? |  |  |  |
| Pain in your chest? |  |  |  |
| Trouble with your heart or chest? |  |  |  |
| High Blood Pressure? |  |  |  |
| Are you or could you be pregnant? (If yes, how many months?) |  |  |  |
| Implants like hip, knee, pacemakers or metal plates? (Please give details) |  |  |  |
| Hay fever, Asthma or Eczema? (Please state which one) |  |  |  |
| Cold feet, white toes or fingers? (Please state which one) |  |  |  |
| Hepatitis, jaundice or problems with your liver? (Please state which one) |  |  |  |
| Allergies to drugs or medicines? (Or an abnormal reaction to Penicillin?) |  |  |  |
| Any problems with Local Anaesthesia? |  |  |  |
| Do you have any problems with healing (e.g if you cut or bruise yourself) |  |  |  |
| Do you smoke? (If yes, how many per day) |  |  |  |
| Any blood disorder such as anaemia or sickle cell disease? |  |  |  |
| Rheumatic Fever? |  |  |  |
| Have you recently lost or gained significant weight? (Please circle and give approximate weight loss/gain?) |  |  |  |
| Any general illness in the last six months and/or hospital treatment? |  |  |  |