MEDICAL HISTORY FORM (WATERHOUSE PODIATRY & CHIROPODY)

Full Name:	
Address	
Post code:	
Email:	
Tel No:	
Date of Birth:	
G.P. Name:	
& Address:	
Occupation:	

Diagnosed Medical Conditions	Date Diagnosed:
Surgical History:	
Known Allergies:	

Current Medication

PRIVACY: Our privacy policy can be viewed at our clinic and website. We do not hold your details for marketing purposes. If you would like to received an automated appointment reminder, please tick the type of reminder you would prefer:

☐ text ☐ email ☐ voice message to a land line

CANCELLATION POLICY: Please note we kindly ask for 24 hours notice to cancel / amend appointments. Regrettably, unless exceptional circumstances have occurred, appointments missed/cancelled without 24 hours notice will be charged.

CONSENT

I understand that I am to be seen/treated by a Podiatrist.
I confirm that I am aware that Podiatrists may use sharp medical instruments.
I confirm that I am aware that there is currently a Covid-19 pandemic and by being treated there is a small risk of transmission due to mixing with other people. The podiatrist will wear appropriate protective equipment and follow strict infection control protocols to minimise this risk as much as they can.
I therefore consent to treatment with this knowledge.
Please sign below to confirm the above details and consent to treatment

Signed	**Date:**
Print Name:	