Medical History & Medication

Name: _____

Date: _____

Illness (e.g diabetes, high blood pressure, heart attack,stroke, cholesterol anaemia, osteo or rheumatoid arthritis,thyroid)	
Operations / Surgical history	
Injuries (e.g broken bones, road traffic accidents)	
Allergies (e.g latex, iodine, bee stings)	
Social (e.g smoke, drink)	
Any further information	

Medication

(Please give us details of any tablets or inhalers that you use)

Medication	Dosage

It is important to keep our records up to date on your medical status and medication.

We would appreciate if possible, that you could complete this form and return it to the Podiatrist at your next appointment using black ink.

Thank You.