ENABLE PODIATRY
Educate | Advocate | Empower

NICOLA CALLENDER Provider No: 522158EL
Podiatrist | Clinical Director | Consultant Podiatrist NSW Health
B. Pod. M.APodA. M.APP.HRF

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MEDICAL HISTORY FORM – PODIATRIC PATIENT

Full Name: _____ Title: _____

Date of Birth: _____ Occupation: _____

Address: _____

Email Address: _____

Who is your regular GP? _____

How did you hear about Enable Podiatry? Google / word of mouth / doctor / flyer / walked past / social media / Website

Telephone Numbers: (Mobile) _____ (Home) _____

Memberships:

Private Health Fund: _____ Membership Number:_____

Medicare Number: _____Exp Date: _____ IRN (1-6): _____

Department of Veterans Affairs Card Type: _____ Number: _____

Medical Conditions:

Do you have any of the following medical conditions? Please circle YES or NO.

Hypertension High Blood Pressure	Y	N	**Bleeding Disorders**	Y	N
Diabetes	Y	N	**HIV / AIDS**	Y	N
Heart Disease	Y	N	**Movement Disorders**	Y	N
High Cholesterol	Y	N	**Neurological Disorders**	Y	N
Renal Disease	Y	N	**Arthritis**	Y	N

Other? Please specify: _____

Medications: (Please include any blood thinners, cardiac drugs, insulin, chemotherapy drugs and supplements)

_____

_____

_____

Allergies: (latex, iodine, anaesthetics, medications, adhesive tapes) _____

Falls: Have you had any falls in the past 12 months? _____

Surgery: Have you had any surgeries on your hips, knees, ankles or feet? _____

If yes, when and what for? _____

Habits

Do you drink alcohol? _____

If yes, frequency and how many standard drinks? _____

Do you smoke or have a history of smoking? _____ How many per day? _____

How can we help you?

Reason for consultation? _____

Have you sought any previous treatment for this condition? _____

What concerns you most about this condition? _____

What is this condition preventing you from doing? _____

What is your goal from undergoing treatment with our podiatrist? _____

Privacy Agreement and Consent to Treatment:

Privacy Agreement: In order to comply with the Privacy Laws (Privacy Act Amendments – Private Sector – Act 2000) your agreement to the following is required:

I agree to allow the podiatrists employed by Enable Podiatry access to all relevant information regarding my medical condition or history to other health care providers. I understand that to provide the highest medical care, my clinical records may be accessed and reviewed by staff of the practice.

I agree to the use of my email address for all correspondence relating to the practice including; appointments, updates and marketing material. Enable Podiatry will never release these details to any third parties.

I agree that at times photographs maybe required of my hips, legs or feet which will be used to formulate and support my ongoing treatment plan, these images will be kept in your file and not accessed by anyone external to the practice.

If you require any assistance or clarification our helpful staff are on hand to assist you with any concerns you may have.

Print Name: _____

Signed: _____ Date: _____

If you are completing this form online please print and email to **admin@enablepodiatry.com.au** or otherwise simply bring the form with you to your appointment.

Did you know you can book your next appointment online via our website? **www.enablepodiatry.com.au**