

Patient Name.....**Patient No**.....

Assessment

Make a diagnosis of the patient's problem	Signature
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Plan the management of the patient's problem, indicating a time frame Statement to include :- callus reduction, foot health advice, orthotic therapy, etc	Signature
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Patient Name.....**Patient No**.....

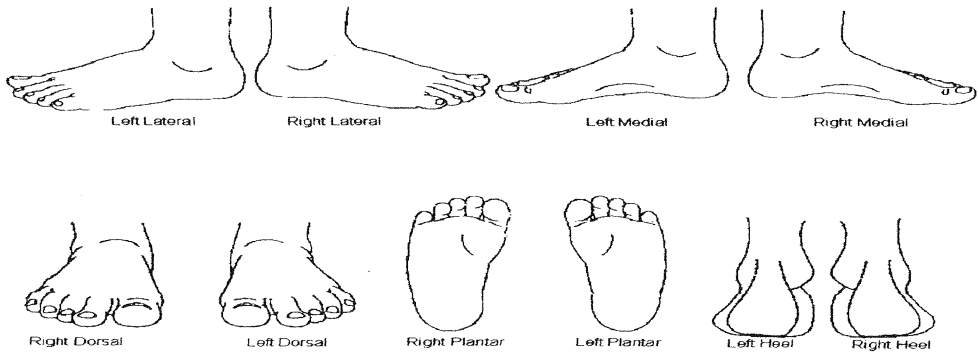
Subjective Evidence Statement

Record the nature of the patient's problem on.....(Date)

Patient Complains of:	Signature
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Describe the symptoms associated with the Patient's problems	Signature
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Describe the onset and duration of the complaint	Signature
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Objective Evidence Statement  Left Lateral Right Lateral Left Medial Right Medial Right Dorsal Left Dorsal Right Plantar Left Plantar Left Heel Right Heel Record sites of lesions on the diagrams. Record the appearance of these lesions. Indicate the site of pain/problems	Signature
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Patient Name.....**Patient No**.....

Record Relevant Surgical History

	Signature
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Record Medication

			Signature
--	--	--	-----------

Explain Significance of the Medical/Surgical History

	Signature
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Patient's Social History

Record exercise levels/activity, smoking, hobbies, mobility, etc

	Signature
--	-----------

Record Relevant Family Medical History

	Signature
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Surname.....

Patient No.....

Forenames.....

Dr Name.....

Address.....

Address.....

Postcode.....

Postcode.....

Phone Landline.....

Tel No.....

Phone Mobile.....

Next of Kin.....
In case of emergency, contact

Date of Birth.....

Occupation.....

Height..... Weight

.....

Has patient signed the consent to treatment form

Yes ☐

No ☐

Has patient signed the consent to photographs form

Yes ☐

No ☐

Staff to complete this section at first appointment:

Is patient suitable for tutorial? PVD ☐ Dermatology ☐ Neurology/Diabetes ☐

Is patient suitable for exams? 1st Year ☐ 2nd Year ☐ 3rd Year ☐ Is this patient high risk? ☐

Assessment files – insert dates assessments undertaken

Vascular Neurological.....Biomechanical.....Other.....

Patient's Medical History

	Signature
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**CONSENT TO TREATMENT AT
THE WALES CENTRE FOR PODIATRIC STUDIES**

I consent to treatment which may be necessary for the maintenance and improvement of my foot health, on the understanding that such treatments will be fully explained to me and will not be implemented without my agreement.

I accept that I will be required to provide relevant information about my health status.

SIGNED.....DATE.....

NAME.....
(In block capitals)

In the case of a child under 16 years of age the consent should be provided on their behalf by a parent or guardian.

Confidential Patient Details

UNIVERSITY OF WALES INSTITUTE CARDIFF

To all patients attending the Wales Centre for Podiatric Studies

As part of clinical practice it is necessary for the Centre to collate records. We request you complete this form on arrival and return it to the reception staff. If you require assistance please ask either the clinical supervisor or the reception staff who will be happy to help.

Patient number _____ Date of birth ____/____/____ Title _____

Surname _____

Forenames _____

Address _____

Postcode _____ Telephone No _____

Occupation _____ Weight _____ Height _____

Activities (e.g. Sports, walking, running etc) _____

Doctor _____

Address _____

Doctor's Tel _____

Referred by _____

Do you or any of your close family suffer from?

	Self	Family
Diabetes		
Arthritis		
High Blood pressure		
Heart problems		
Digestive disorders		
Allergies		
Other		

From time to time podiatry students may access your record card as part of their course work, for case studies or projects. In such situations, the permission of the Head of Centre must be obtained, and record cards are never allowed to leave the clinical area. Such work makes an important contribution to the students' education, and they are all aware of the importance of confidentiality and anonymity. Should you object to your details being used for such work, please tick this box. This means that we will contact you to request your formal permission to use your details should the situation arise. ☐

Patient Name..... Patient No.....

Treatment Record

[illegible]

Patient Name.

Patient No.....

Treatment Record

[illegible]