Initial Consultation Medical Questionnaire

Miss / Mrs / Ms / Mr / Master

Name: _____

Address: _____

_____Suburb_____Postcode_____

Home phone number: _____

Work phone number: _____

Mobile phone number: _____

Email address (please print):_____

D.O.B: _____/_____/_____

Medicare number: _____

DVA number (department veteran affairs): _____

Next of kin: _____ Phone number: _____

Reason for attending today: _____

_____

GP's name: _____

GP's Address: _____

_____

GP's Phone number: _____

Consultant / Specialist's name: _____

Address: _____

Phone number: _____

Have you visited any other medical professionals about this problem?

Yes / No_If yes what type of professional:_____

Please state your current medical conditions:

_____

_____

_____

Please turn the page over

Barefeet Podiatry North Sydney

Please list any lower limb or back surgeries: _____

Medication list:

Name:	Dosage:	Amount per day:

Occupation: _____

Consent for photographs to be taken of your lower limb to be utilised for educational purposes. Please note the photographs will not be identifiable to whom the person is in the photo.

Signature: _____

I consent to the podiatric treatment that will be undertaken, after a management plan will be discussed.

Signature: _____

Date: _____

I found out about Barefeet Podiatry by:

Walked by	Referred	Yellow pages
Web Search	GP referred	Work in area
Live in area	Other _____	