A STUDY OF DIFFERENT TYPES OF TREATMENT FOR VERRUCAE

PODIATRIST TREATMENT ASSESSMENT

(Please complete the relevant section for each appointment)

Participant Number:
(For office use only) ☐☐ - ☐☐☐☐

Type of verruca ***(please cross all that apply)***

- plantar calcaneous ☐
- plantar MTPJ ☐
- mosaic ☐
- other ☐ **If other** (please specify) _____

Number of verrucae at baseline ☐☐

Did the patient express a preference for a treatment? If so which treatment did they prefer? (Please cross one box only)

- The patient prefers to be treated with salicylic acid ☐
- The patient prefers to be treated with cryotherapy ☐
- The patient did not express a preference ☐

For those patients assigned to salicylic acid group:
What is the Weight of Verrugon tube(s) in grams at start and end of study?

	Start weights:		Finish weights:	
Tube 1	☐.☐☐	Tube 1	☐.☐☐	Tube 1
Tube 2	☐.☐☐	Tube 2	☐.☐☐	Tube 2

Please fill in the following information for the first verruca you treated

Appointment date	Treatment given	If they had cryotherapy					General Comments
		How many times did you apply it	How long did each application last (in seconds)	Do you think sufficient freezing took place	Did the patient ask you to stop the treatment?	If Yes, why?	
☐☐ / ☐☐ / ☐☐☐☐	☐ Salicylic acid ☐ Cryotherapy ☐ Non given	☐☐	☐☐	☐ Yes ☐ No	☐ Yes ☐ No		
☐☐ / ☐☐ / ☐☐☐☐	☐ Salicylic acid ☐ Cryotherapy ☐ Non given	☐☐	☐☐	☐ Yes ☐ No	☐ Yes ☐ No		
☐☐ / ☐☐ / ☐☐☐☐	☐ Salicylic acid ☐ Cryotherapy ☐ Non given	☐☐	☐☐	☐ Yes ☐ No	☐ Yes ☐ No		
☐☐ / ☐☐ / ☐☐☐☐	☐ Salicylic acid ☐ Cryotherapy ☐ Non given	☐☐	☐☐	☐ Yes ☐ No	☐ Yes ☐ No		

3947140862

Please fill in the following information for the first verruca you treated

Appointment date	Treatment given	If they had cryotherapy					General Comments
		How many times did you apply it	How long did each application last (in seconds)	Do you think sufficient freezing took place	Did the patient ask you to stop the treatment?	If Yes, why?	
☐☐ / ☐☐ / ☐☐☐☐	☐ Salicylic acid ☐ Cryotherapy ☐ Non given	☐☐	☐☐	☐ Yes ☐ No	☐ Yes ☐ No		
☐☐ / ☐☐ / ☐☐☐☐	☐ Salicylic acid ☐ Cryotherapy ☐ Non given	☐☐	☐☐	☐ Yes ☐ No	☐ Yes ☐ No		
☐☐ / ☐☐ / ☐☐☐☐	☐ Salicylic acid ☐ Cryotherapy ☐ Non given	☐☐	☐☐	☐ Yes ☐ No	☐ Yes ☐ No		
☐☐ / ☐☐ / ☐☐☐☐	☐ Salicylic acid ☐ Cryotherapy ☐ Non given	☐☐	☐☐	☐ Yes ☐ No	☐ Yes ☐ No		

1937140869

Please fill in the following information for the first verruca you treated

Appointment date	Treatment given	If they had cryotherapy					General Comments
		How many times did you apply it	How long did each application last (in seconds)	Do you think sufficient freezing took place	Did the patient ask you to stop the treatment?	If Yes, why?	
☐☐ / ☐☐ / ☐☐☐☐	☐ Salicylic acid ☐ Cryotherapy ☐ Non given	☐☐	☐☐	☐ Yes ☐ No	☐ Yes ☐ No		
☐☐ / ☐☐ / ☐☐☐☐	☐ Salicylic acid ☐ Cryotherapy ☐ Non given	☐☐	☐☐	☐ Yes ☐ No	☐ Yes ☐ No		
☐☐ / ☐☐ / ☐☐☐☐	☐ Salicylic acid ☐ Cryotherapy ☐ Non given	☐☐	☐☐	☐ Yes ☐ No	☐ Yes ☐ No		
☐☐ / ☐☐ / ☐☐☐☐	☐ Salicylic acid ☐ Cryotherapy ☐ Non given	☐☐	☐☐	☐ Yes ☐ No	☐ Yes ☐ No		

THANK YOU FOR TAKING THE TIME TO ASSESS THIS PATIENT. PLEASE RETURN THIS FORM TO THE UNIVERSITY OF YORK IN THE PRE-PAID ENVELOPE.