KANSAS FOOT CARE ASSOCIATES, P.A.
DISEASES & SURGERY OF THE FOOT

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Initial Visit – Medical History

Patient Name: _____ **Date of Birth:**_____ Age: _____ Sex: **M** **F**

Primary Care Physician: _____ Height: _____ Weight:_____

Drug Allergies: _____ Metal allergy: **Yes** **No** Shoe Size:___

List your current medications: _____

List any surgeries or hospitalizations within the past 5 years: _____

Chief complaint (Nature of problem and location): _____

Onset: **gradual** **fast** Progression: **stable** **improving** **worsening** Duration (days, wks, mths): _____

Past treatment for this complaint: _____

Was there any trauma or prior injury (please circle)? Yes or No **Is this a work-related injury (please circle)?** Yes or No

Pain level for this complaint: (No pain) **0 1 2 3 4 5 6 7 8 9 10** (Most pain) Overall Health: **Good** **Fair** **Poor**

Do you have Diabetes? **Yes** **No** When were you diagnosed?: _____ Most recent HgbA1C: _____

Most recent fasting blood glucose level: _____ Most recent appt with Doctor managing diabetes: _____

Review of Systems - Please circle all that apply at the current time

Constitutional: Fever Headache Nausea Dizziness Chills Vomiting

Cardiovascular: Muscle Cramping Swelling Cold Feet COPD Pacemaker Tightness in Chest Varicosities

Endocrine: Very Dry Skin Cuts Take Longer to Heal Unusual Fatigue

Eyes, Nose, Mouth & Throat: Ringing in Ears Decreased Hearing Difficulty Swallowing

Gastrointestinal: Upset Stomach Constipation

Genitourinary: Painful Urination Blood in Urine Sexually Transmitted Disease (STD)

Musculoskeletal: Back Pain Joint Pain Muscle Pain Bone Pain Joint Implants _____

Integumentary: Dermatitis Eczema Athlete's Foot Psoriasis Rash Other Skin Condition

Neurological: Numbness Tingling Seizures Tremors Other Neurological Problems

Hematologic/Lymphatic: Bloating Swelling Pitting Edema Inability to Stop Bleeding Bruise Easily Poor Circulation

Continued on Back

Family Health History: Have you or a family member ever had the following?			
CONDITION	**PATIENT**	**FAMILY**	**EXPLAIN and LIST WHO (EX: Mother, Father, sister, etc)**
Arthritis	**Yes No**	**Yes No**	
Bleeding problems	**Yes No**	**Yes No**	
Cancer	**Yes No**	**Yes No**	
Circulatory problems	**Yes No**	**Yes No**	
Epilepsy / seizure disorder	**Yes No**	**Yes No**	
Heart problems	**Yes No**	**Yes No**	
High Blood Pressure	**Yes No**	**Yes No**	Last BP:
Kidney problems	**Yes No**	**Yes No**	
Liver problems	**Yes No**	**Yes No**	
Lung problems	**Yes No**	**Yes No**	
Other medical condition	**Yes No**	**Yes No**	
Rheumatic fever	**Yes No**	**Yes No**	
Stomach / Bowel problems	**Yes No**	**Yes No**	

Lifestyle Information:

Have you ever smoked? **Yes No** If yes, Packs per day: _____ Number of years: _____

Do you use any form of tobacco? **Yes No** If yes, what form: _____ Do you drink alcohol regularly? **Yes No**

Women: Are you, to your knowledge, pregnant or possibly pregnant? **Yes No**

What is your marital status? _____ Do you have any children? **Yes No**

Are your parents living? **Yes No** If deceased, what did they die from? _____

What is/was your occupation? _____ Employment status: _____

I consent to having x-rays taken when medically necessary at any given time ☐ **yes** ☐ **no**

I certify that my answers are true and complete to the best of my knowledge.

Patient Signature: _____ Date: _____

For office use only: BP: _____ P: _____ Initials: _____