Foot Specialists of Kansas City, P.A.
www.kcfeet.com

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Patient Information

Last Name_____ First Name _____ M.I._____ Nickname _____

Birth Date ____/____/_____ Age _____ Soc. Sec. #_____-_____-_____ Sex: ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Primary Number (_____) _____-_____ ☐ Home ☐ Cell ☐ Work

Secondary Number (_____) _____-_____ ☐ Home ☐ Cell ☐ Work

Email Address: _____

Employer: _____

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

This is collected per government requirements:

Race:
- ☐ Black/African American
- ☐ American Indian/ Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian/ Pacific Islander
- ☐ White
- ☐ Unknown/Refuse

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ Unknown/Refuse

Language:
- ☐ English
- ☐ Spanish
- ☐ Other _____

Primary Physician _____ (FIRSTNAME) _____ (LASTNAME)

Phone Number (_____) _____ - _____ Date Last Seen: _____/____/_____

Referring Physician _____ (FIRSTNAME) _____ (LASTNAME) Phone Number (_____) _____ - _____

How did you hear about our office? _____

Is this visit related to an accident? ☐ Yes ☐ No Date of Accident _____/_____/_____ At Work? ☐ Yes ☐ No

Insurance Information

☐ I do not have medical insurance

Primary Ins. Co. Name_____ ID#_____ Suffix#____ Group#_____

Name of Policy Holder (if other than self)_____ Policy Holder's DOB ____/____/_____

Secondary Ins. Co. Name_____ ID#_____ Suffix#____ Group#_____

Name of Policy Holder (if other than self)_____ Policy Holder's DOB ____/____/_____

Who Will Be Responsible For Your Account?

☐ Self (if self leave blank) ☐ Spouse ☐ Parent ☐ Other

Name_____ SSN#_____-_____-_____ Birth Date____/____/_____

Home Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____ Employer _____

Release of Medical Information & Emergency Contacts

1. Name _____ ☐ Emergency Contact
   Relationship _____ Phone Number (_____) _____ - _____
2. Name _____
   Relationship _____ Phone Number (_____) _____ - _____

Name _____ DOB _____/_____/_____ Date _____/_____/_____

Pharmacy Information ☐ I do not have a pharmacy

Pharmacy Name _____ Cross-Streets _____ Phone (_____) _____-_____

Drug Allergies ☐ No Known Drug Allergies

☐ Penicillin	☐ Aspirin	☐ Other Anti-Inflammatory Medications (NSAIDS):	☐ Local Anesthetics
☐ Sulfa Drugs	☐ Codeine		☐ General Anesthetics
☐ Other Antibiotics:	☐ Other Pain Meds:		☐ Latex
_____	_____	_____	☐ Iodine/Shellfish
_____	_____	_____	☐ Tape
Other Medication Allergies:			

Family History ☐ No Family History ☐ Adopted

Arthritis	☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Sister ☐ Brother ☐ Maternal Grandfather ☐ Maternal Grandmother ☐ Paternal Grandfather ☐ Paternal Grandmother
Cancer	☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Sister ☐ Brother ☐ Maternal Grandfather ☐ Maternal Grandmother ☐ Paternal Grandfather ☐ Paternal Grandmother
Diabetes	☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Sister ☐ Brother ☐ Maternal Grandfather ☐ Maternal Grandmother ☐ Paternal Grandfather ☐ Paternal Grandmother
Heart Disease	☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Sister ☐ Brother ☐ Maternal Grandfather ☐ Maternal Grandmother ☐ Paternal Grandfather ☐ Paternal Grandmother
Hypertension (High Blood Pressure)	☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Sister ☐ Brother ☐ Maternal Grandfather ☐ Maternal Grandmother ☐ Paternal Grandfather ☐ Paternal Grandmother
Stroke	☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Sister ☐ Brother ☐ Maternal Grandfather ☐ Maternal Grandmother ☐ Paternal Grandfather ☐ Paternal Grandmother
Other	

Social History

Tobacco Use: ☐ Never Smoker ☐ Former Smoker ☐ Every Day Smoker ☐ Some Day Smoker ☐ Chewing Tobacco

Alcohol Use: ☐ Never Drink ☐ Former Drinker ☐ Occasional Use ☐ Moderate Use ☐ Heavy Use

Illicit Drug Use: ☐ No Drug Use ☐ In the Past ☐ Current Drug Use (Type: _____)

Medications (Include over the counter medications and supplements.) ☐ Not taking any medications

Name	Dosage	Frequency

Name _____ DOB _____/_____/____ Date _____/_____/_____

Surgical History ☐ No Surgical History

Surgery Name	Year	Surgery Name	Year

Patient Medical History (Past and Present) ☐ No Medical History

- ☐ Alzheimer's/Dementia
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Arthritis
  - ☐ Rheumatoid
  - ☐ Osteoarthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer History
  - ☐ Bone
  - ☐ Brain
  - ☐ Breast
  - ☐ Lung
  - ☐ Pancreatic
  - ☐ Prostate
  - ☐ Skin
- ☐ Diabetes
  - ☐ Insulin
  - ☐ Non-insulin
- ☐ Drug Abuse
- ☐ Epilepsy
- ☐ GERD/Acid Reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Hearing Problems
- ☐ Heart Disease
  - ☐ Congestive Heart Failure
  - ☐ Heart Attack
- ☐ Hepatitis
  - ☐ A ☐ B ☐ C
- ☐ Hernia
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hypertension (High Blood Pressure)
- ☐ Kidney Problems/ Dialysis
- ☐ Liver Disease
- ☐ Lung Disease
  - ☐ Bronchitis
  - ☐ COPD
  - ☐ Emphysema
- ☐ Muscle Disease
- ☐ Nerve Disorder
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Polio
- ☐ Poor Circulation
- ☐ Psychiatric Conditions
- ☐ PVD/PAD
- ☐ Restless Leg Syndrome
- ☐ Shortness of Breath
- ☐ Skin Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Swelling (Ankle/Foot)
- ☐ Thrombophlebitis/ blood clots
- ☐ Thyroid Disorder
- ☐ Ulcer (GI)
- ☐ Varicose Veins
- ☐ Vascular Disease

Other Medical History:

_____

_____

_____

_____

Additional Info?

Is there any additional health information you feel like the doctor needs to know?_____

_____

_____

_____