FOOT PAIN CENTER OF KANSAS CITY

Medical Information

Patient Name _____ Date _____

Please describe your primary foot problem: _____

_____

Which foot? ❒ Right ❒ Left Ankle? ❒ Right ❒ Left Leg? ❒ Right ❒ Left
How long has it been present? _____Days _____Weeks _____Months _____Years
The pain is ❒ Burning ❒ Sharp ❒ Dull ❒ Aching ❒ Shooting (electrical) ❒ Throbbing ❒ Tingling
How did the pain start? ❒ Suddenly ❒ Gradually ❒ Unknown
Does the pain cause ❒ Limping ❒ Preventing falling asleep ❒ Waking up from sleep ❒ Missing work
What makes the pain better? ❒ Resting ❒ Removing shoes ❒ Wearing shoes ❒ Massage ❒ _____
What makes the pain worse? ❒ Walking ❒ Standing ❒ Wearing shoes ❒ Walking without shoes ❒ _____
Have you tried anything for this problem or has it been treated before? ❒No ❒Yes When? _____
What was done? _____

Please rate your pain (at its worst): [Please circle]
1- very mild **2**- discomfort **3**- tolerable **4**- distressing **5**- very distressing **6**- intense 7- very intense
8- utterly horrible **9**- excruciating/unbearable **10**- unspeakable

Secondary foot/ankle problems: _____

Past Medical History: Current weight _____ Height _____ Shoe Size _____ Width _____

Please check any of the following you currently have or have had in the past: ❒None

❒ Asthma
❒ Anemia
❒ Anxiety
❒ Bleeding Disorder (type) _____
❒ Cancer (type) _____
❒ Congestive Heart Failure
❒ Dementia
❒ Depression
❒ Diabetes-❒Type 1 ❒Type II Year diagnosed_____
❒ Emphysema
❒ Fibromyalgia
❒ Gout
❒ Heart Attack (Year) _____
❒ Hemophilia
❒ Hepatitis A B or C
❒ High Blood Pressure
❒ High Cholesterol
❒ HIV
❒ Joint Replacement ___Hip ___Knee ❒Rt ❒Lt
❒ Keloid/Thick Scar
❒ Kidney Disease
❒ Liver Disease
❒ Mitral Valve Prolapse
❒ Neuropathy
❒ Osteoarthritis
❒ Osteoporosis
❒ Pacemaker
❒ Phlebitis (blood clots)
❒ Post Traumatic Stress Disorder
❒ Rheumatoid Arthritis
❒ Stomach Ulcer
❒ Stroke Year? _____
❒ Thyroid Disease

❒Other:_____

Medications: (Please include over-the-counter and herbal medications, vitamins and diet supplements)
❒ None ❒See List (please provide list to front desk) _____
_____
_____

Allergies: ❒ None
❒ Penicillin ❒ Aspirin ❒ Cortisone ❒ Novocaine/lidocaine ❒ Adhesive Tape ❒ Metals
❒ Latex ❒ Codeine ❒ Sulfa Medications ❒ Iodine/Betadine ❒ Other:_____

Type of Reaction: _____

Any problems with general anesthetic? ❒No ❒Yes Type of reaction: _____

Surgical History: (Please list any previous surgeries and the approximate dates, including foot or ankle surgery)
❒None _____
_____

Family History: (Please list any major medical conditions in your immediate family) (Mother, Father, Sister, Brother)
❒ Unknown _____
_____

Personal Social History:
Do you smoke? ❒Yes Packs/Day _____ #of years _____
❒No ❒No, but I have previously. How many years did you smoke? _____
When did you quit? _____
Do you drink alcohol? ❒No ❒Yes Amount? _____ How often? _____

Review of Systems: (Do you **CURRENTLY** have any of the following problems?) Please circle

	NO	**If YES, please explain:**
General: (unexpected weight loss/gain, fatigue, loss of appetite)	❒	_____
Ear/nose/throat problems (hearing loss, sinus prob., sore throat)	❒	_____
Endocrine (difficulty tolerating cold/heat, frequent thirst, hunger)	❒	_____
Heart Problems (chest pain, irregular heart beat, palpitations)	❒	_____
Respiratory problems (shortness of breath, wheezing, coughing)	❒	_____
Gastrointestinal problems (abdominal pain, diarrhea, vomiting)	❒	_____
Urinary problems (increased frequency, pain, blood in urine)	❒	_____
Skin problems (rashes, excessive dryness, itching, skin cancer)	❒	_____
Musculoskeletal problems (muscle cramps, joint pain, walking aid)	❒	_____
Neurological problems (numbness, weakness, headaches)	❒	_____
Psychiatric problems (depression, dementia, chronic fear)	❒	_____
Hematologic problems (bruising easily, rare blood type)	❒	_____

Patient's / Guardian's Signature _____Date_____