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 bothering you? (please enter a #) ___Days ___Weeks ___Months ___Years
If there is pain, is it ❒ Burning ❒ Dull ❒ Sharp ❒ Aching ❒ Shooting (electrical) ❒ Throbbing ❒ Tingling
Does the pain cause ❒ Limping ❒ Preventing falling asleep ❒ Waking up from sleep ❒ Missing work
Have you been treated or have you tried anything for this problem? ❒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 electrician **8**- utterly horrible **9**- excrutiating/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:

❒ Asthma
❒ Anemia
❒ Bleeding Disorder (type) _____
❒ Cancer (type) _____
❒ Congestive Heart Failure
❒ Depression
❒ Diabetes- Insulin Dependent
❒ Diabetes- Non-Insulin Dependent
❒ Emphysema
❒ Gout
❒ Heart Disease
❒ Hemophilia
❒ Hepatitis
❒ 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
❒ Phlebitis (blood clots)
❒ Rheumatoid Arthritis
❒ Stomach Ulcer
❒ Stroke
❒ Thyroid Disease

❒**None** ❒Other:_____

Medications: (Please include over-the-counter and herbal medications, vitamins and diet supplements)
❒ None ❒See List _____

_____

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 their approximate dates)

_____

_____

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

_____

_____

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?)

	NO	**If YES, please explain:**
General: (unexpected weight loss/gain, fatigue, loss of appetite)	❒	_____
Endocrine (difficulty tolerating cold/heat, frequent thirst, hunger)	❒	_____
Heart Problems (chest pain, irregular heart beat, palpitations)	❒	_____
Skin problems (rashes, excessive dryness, itching, skin cancer)	❒	_____
Musculoskeletal problems (muscle cramps, joint pain, walking aid)	❒	_____
Neurological problems (numbness, weakness, headaches)	❒	_____
Psychiatric problems (depression, anxiety, chronic fear)	❒	_____
Hematologic problems (bruising easily, rare blood type)	❒	_____

COMMENTS: _____

_____

Patient's / Guardian's Signature _____Date_____

Doctor's Signature _____ Date _____