PODIATRY ASSOCIATES
FOOT CARE SPECIALISTS
Diplomates, American Board of Podiatric Surgery

KANSAS
8901 West 74th Street, Suite 200
Shawnee Mission, KS 66204

MISSOURI
1004 Carondelet Drive
Kansas City, MO 64114

Dr. Michael Nachlas ◆ Dr. Mitchell Dorris ◆ Dr. Todd VanWyngarden ◆ Dr. Holly Korges

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

Employer ______ Occupation ______

Email Address: ______

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 ______

I give my consent to the physician and staff at Podiatry Associates to leave messages regarding my care at the following: ☐ Home ☐ Cell ☐ Work ☐ Email ☐ None

Primary Physician ______ (FIRST NAME) ______ (LAST NAME) Phone Number (____) ___-___

Referring Physician ______ (FIRST NAME) ______ (LAST NAME) Phone Number (____) ___-___

How did you hear about our office? ______

Is this related to an injury ☐ Yes ☐ No Date of Injury ___/___/___ Activity when injured ______

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# ______ Group # ______

Name of Policy Holder (if other than self) ______ Policy Holder's DOB ___/___/___

Secondary Ins. Co. Name ______ ID# ______ Group # ______

Name of Policy Holder (if other than self) ______ Policy Holder's DOB ___/___/___

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

☐ Self (leave blank) ☐ Spouse ☐ Mother ☐ Father

Name ______ Soc. Sec. # ___-___-___ 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 (____) ___-___

Patient Name ______________________ DOB ______________ Date ______________

Main Foot Complaint:

When did this problem start? ________________________________

Pharmacy Information

☐ I do not have a pharmacy

Pharmacy Name ______________________ Cross-Streets ______________ Phone (___) ____ - ______

Family Physician ________________________________

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

Check the appropriate box for family history.

☐ No Family History ☐ Adopted

	Yes	No
Arthritis		
Cancer		
Diabetes		
Heart Disease		
Hypertension		
Stroke		
Other (What?)		

Social History

Tobacco Use:

- ☐ Never Smoked
- ☐ Former Smoker
- ☐ Every Day Smoker
- ☐ Some Day Smoker
- ☐ Chewing Tobacco

Alcohol Use:

- ☐ Never Drink
- ☐ In the Past
- ☐ Occassional Use
- ☐ Moderate Use
- ☐ Heavy Use

Illicit Drug Use:

- ☐ No Drug Use
- ☐ In the Past
- ☐ Current Drug Use (Type:______________________)

Medications

(Include over the counter and supplements) ☐ Not Taking any medications

Name	Dosage	Frequency

Patient Name ______________________ DOB ______________ Date ______________

Surgical History

☐ No Surgical History

Surgery Name	Year	Surgery Name	Year

Patient Medical History (past & present)

- ☐ Alzheimer's/Dementia
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Arthritis
  - ☐ Rheumatoid
  - ☐ Osteoarthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer History
  - ☐ Bone
  - ☐ Pancreatic
  - ☐ Brain
  - ☐ Prostate
  - ☐ Breast
  - ☐ Skin
  - ☐ Lung
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Circulatory Problems
- ☐ Diabetes
  - ☐ Insulin
  - ☐ Type 1
  - ☐ Non-insulin
  - ☐ Type 2
- ☐ Epilepsy
- ☐ Foot or Leg Cramps
- ☐ GERD/Acid Reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Hearing Problems
- ☐ Heart
  - ☐ Congestive Heart Failure
  - ☐ Heart Attack
  - ☐ Artifical Valves
- ☐ Hemophilia
- ☐ Hepatitis
  - ☐ A ☐ B ☐ C
- ☐ Hernia
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hypertension (High Blood Pressure)
- ☐ Kidney Problems/Dialysis
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
  - ☐ Bronchitis
  - ☐ COPD
  - ☐ Emphysema
- ☐ Muscle Disease
- ☐ Nerve Disorder
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Polio
- ☐ Poor Circulation
- ☐ Psychiatric Conditions
- ☐ PVD/PAD
- ☐ Radiation Treatments
- ☐ Restless Leg Syndrome
- ☐ Shortness of Breath
- ☐ Skin Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Swelling (Ankle/Foot)
- ☐ Thrombophlebitis/blood clots
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcer (GI)
- ☐ Varicose Veins
- ☐ Vascular Disease

Other Medical History:

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Additional Info?

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

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