Kansas City Foot Specialists

Medical Record Update Form

(Each section MUST be completed if it does not apply write N/A)

Patients Name: _____

Address: _____

Date of Birth: _____

Primary Insurance: _____

Secondary Insurance: _____

Primary Care Provider (Must list to be seen): _____ Date Last Seen: _____

Drug Allergies/Sensitivities (List the actual drug and not the drug class): _____

Patient Phone #: _____ ER Contact Person/Relationship/Ph# : _____

Date	Medication List (Drug name req'd)	Date	Past Surgical History/Hospitalizations	
		Date	**Hospitalizations**	

Family History of

	Family/Self
Alzheimer's	
Breast CA	
Heart Dx	
Cerebrovas. Dz	
Cervical Cancer	
Colon CA	
Depression	
Diabetes	
Anemia	
Glaucoma	
Hyperchol.	
Hypertension	
Ovarian CA	
Prostate CA	
Skin CA	
Thyroid Dz	
Arthritis	
Other	

List any **durable equipment** you've received in the **past 5 years** that might relate to today's visit.

1.

2.

3.

4.

5.

Social History

☐ Married ☐ Single

☐ Divorced ☐ Widow(er)

☐ Lives Alone ☐ Separated

Occupation: _____

Religious Preference: _____

Advance Directive? ☐ Yes ☐ No
If Yes, Date: _____

Signature: _____ Date: _____