Great Lakes FOOT & ANKLE SPECIALISTS

DR. JEFFREY A. SZCZEPANSKI

10161 E Pickwick Ct. Suite. E, Traverse City, MI 49684 Phone 231-935-8800 Fax 231-935-8801

www.GreatLakesFoot.com

Patient Information

Patient Name____ **Date of Birth**

First Middle Last ______/_____/__________

Home Mailing Address____

City State Zip

HOME Phone Number__________________________ **CELL Number**________________________

EMAIL ______________________________________

Patient is ( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced

In case of emergency whom should we notify? ____

Phone number of person to call in emergency _______________**Relationship**__________________

Employment Status ( ) Employed ( ) Not employed ( ) on temporary leave ( ) retired

Employer Name____

Address____

Business Phone Number___________________ **Job Title/Description**_______________________

Spouse Employed By______________________ **Spouse Business Phone Number**______________

Spouse Business Address____

Responsible Party (if other than parent/spouse) ____

Head of Household or Parent with Custody of Minor

Whom may we thank for referring you to this office? __________________**Relationship**__________

Primary Care

Primary Care Physician ____

Address ____

____

City **State** **Zip Code**

Phone Number ____________________________ **Last Seen** __________________________

Turn over to continue

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Foot/Ankle Issues

Please describe your primary foot problem____

How long has it been bothering you? _______Days________ Weeks______ Months________ Years

Have you been treated for this problem ( ) Yes ( ) No If yes, when and what was done? _______

____

Have you treated this problem at home? ( ) Yes ( ) No If yes how? _________________________

Have you injured your feet/ankles before? ____

____

Medical History

What kind of work do you do? ____

Height____________________ Weight__________________ Shoe Size___________________________

Are you in ( ) Good Health ( ) Fair Health ( ) Poor Health

Are you subject to prolonged bleeding or healing difficulties? ___________________________________

Are you under the care of a doctor? ( ) Yes ( ) No If yes, state the reason_________________________

____

I have (or) have had the following: (Please indicate (1) for have or (2) for previously had

___Anemia	___Blood Clots	___Hepatitis	___Joint Replacement	___Stomach Ulcer
___Arterio Sclerosis	___Cancer	___Kidney Trouble	___Leg Cramps	___Stroke
___Arthritis	___Diabetes	___Heart Trouble	___Tuberculosis	___Varicose Veins
___Asthma	___Epilepsy	___High Blood Pressure	___Lower Back Pain	___Venereal Disease
___Bleeding Tendencies	___Gout	___HIV/AIDS	___Polio	

Explain any of the above conditions you have had____

____

Have any of your family members had Diabetes, Cancer, Heart Disease or other serious conditions? If yes, please list relation and condition(s) ____

Are you pregnant? ( ) Yes ( ) No Last menstrual period ______________________________________

Do you exercise? ( ) Yes ( ) No If yes, How often? ____

Do you smoke? ( ) Yes ( ) No If yes, How much? ____

If you quit, when did you quit? __________________How long did you smoke? ___________________

Alcoholic beverages (including beer and wine): How many drinks per day? _____________________

Do you use illicit drugs such as medical marijuana, cocaine…? ( ) Yes ( ) NO If yes, explain

____

Please list all of the hospitalizations and surgeries (and surgery dates) you have had _______________

____

Have you had any : X-rays, Bone Scans, MRI done at Munson Medical Center or Novello within the last 3 months on the affected area(s)? ( ) Yes ( ) No If yes, Explain _________________________________

Medications/ Allergies

What Medications are you taking? ____

____

Name of your Pharmacy ___________________________ Location ________________________________

( ) I am not allergic to anything to my knowledge.

( ) I am allergic to (Please check):

___Adhesive Tape	___Codeine	___Lidocaine	___NSAIDS	___Sulfa
___Antihistamines	___Demerol	___Mercurials	___Nylon/Plastics	___Sutures
___Aspirin	___Iodine	___Merthiolate	___Penicillin	___Other

Please explain the type of “Allergies” reaction you have had ____________________________________