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 ____/____/____

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

Home Mailing Address _____ Phone Number _____

Whom may we thank for referring you to this office? _____ Relationship _____

Preferred Contact method for appointment reminders AND patient portal:

Email _____

( ) Email ( ) Web Portal ( ) Text Message ( ) Phone

Primary Care

Primary Care Physician _____
Address _____
_____
City State Zip Code
Phone Number _____ Last Seen _____

Insurance

Primary Insurance _____
Secondary Insurance _____
Policy Holder (if not patient)
Name _____
First Middle Initial Last
Date of Birth ____/____/____ Relationship to Patient _____

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 tests (X-rays, Bone Scans, MRI) done at Munson Medical Center 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 _____