Great Lakes
FOOT & ANKLE SPECIALISTS
10161 E Pickwick Ct. Suite. E, Traverse City, MI 49684
www.GreatLakesFoot.com
DR. JEFFREY A. SZCZEPANSKI
Phone 231-935-8800 Fax 231-935-8801

Todays Date _____/_____/_____

Patient Information

Patient Name _____ _____/_____/_____
First Middle Last Date of Birth

Mailing Address _____
City State Zip Code

Physical Address _____
City State Zip Code

HOME Phone _____ **CELL Number** _____
May we leave a detailed message at home? ( ) Yes ( ) No May we leave a detailed message on cell? ( ) Yes ( ) No

EMAIL _____

Primary Health Insurance _____

Policy Number _____ **Group Number** _____

Secondary Health Insurance _____

Responsible Party (if other than parent/spouse) _____

Policy Number _____ **Group Number** _____

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

Emergency Contact _____ **Relationship**_____

Emergency Contact Phone _____

Whom may we discuss your health information with? (List all) _____

_____

Employment Status ( ) Employed ( ) Not employed ( ) on Temporary Leave ( ) Retired

Employer Name_____

Work Number_____ **Job Title/Description** _____

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

Primary Care

Primary Care Physician _____

PCP Address _____
City State Zip Code

Phone Number _____ **Date Last Seen** _____

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? _____

_____

Have you had imaging (X-rays, Bone Scans, MRI) done in the last 3 months on the affected area(s)?
( ) Yes ( ) No If yes, what facility? ____ Munson Healthcare ____ Novello ____ Other _____

Turn over to continue

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Medical History

What kind of work do you do? _____

Most Recent Height _____ **Weight** _____ **Shoe Size** _____

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

Are you subject to prolonged bleeding or healing difficulties? _____

I have (or) have had the following:

___Anemia	___Blood Clots	___Gout	___HIV/AIDS	___Low Back Pain
___Arthritis	___Cancer	___Hepatitis	___Joint Replacement	___Polio
___Asthma	___Diabetes	___Heart Trouble	___Kidney Trouble	___Poor Circulation
___Bleeding Tendencies	___Epilepsy	___High Blood Pressure	___Leg Cramps	___Stroke

Explain any of the above conditions you have had_____

_____

_____

Has any FAMILY member had Diabetes, Cancer, Heart Disease, or other serious conditions? If yes, please list relation and condition(s) _____

_____

Are you pregnant? ( ) Yes ( ) No

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?** _____

Have you had a drink containing alcohol in the past year? ( ) Yes ( ) No

If yes, how often?___**Once a month or less** ___**2-4 times a MONTH** ___**2-3 times a WEEK** ___**4 or more times a WEEK**

Do you use Marijuana? ( ) Yes ( ) No If yes, how often? _____

Do you have current or past illicit drug use/abuse? ( ) Yes ( ) No If yes, explain_____

_____

Have you fallen in the last year? ( ) Yes ( ) No How many falls? _____

Were you injured? ( ) Yes ( ) No Describe Injuries _____

Do you have an Advanced Directive or Living Will? ( ) Yes ( ) No

Please list all hospitalizations and surgeries (and surgical dates) you've had that are related to your foot and ankle conditions _____

_____

Medications and Allergies

List all Medications and the dosage _____

_____

_____

Name of your Pharmacy _____ **Location** _____

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

( ) I am allergic to (Check all that apply):

___ Adhesive Tape	___ Codeine	___ NSAIDS	___ Lidocaine/Local Anesthetic	___ Surgical Metal
___ Sulfa	___ Iodine	___ Penicillin	___Other _____	

Please explain the type of "Allergies" reaction you have had _____

Please sign below that you have reviewed the information above, and it is correct to the best of your knowledge.

_____ _____

Signature of Patient or Guardian **Date**