DR. JEFFREY A. SZCZEPANSKI DR. KEVIN C. BRYANT
3537 W Front St. Suite C., Traverse City, MI 49684 Phone 231-935-8800 Fax 231-935-8801
www.GreatLakesFoot.com

Patient Information

Patient Name____
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

Mailing Address______________________________ Phone Number______________

Whom may we thank for referring you to this office? ______________Relationship__________

Preferred Contact method for appointment reminders:

( ) 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 ______________________

**** If you are here for nailcare service, please note that Medicare now requires the <u>EXACT</u> date of your last primary care physician visit. If you are unable to provide this information, it will result in <u>out of pocket payment</u>****

Turn over to continue

Great Lakes FOOT & ANKLE SPECIALISTS

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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 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 ____________________________

____