EAST LANSING
PODIATRY
ASSOCIATES

Michael D. Papson, DPM
612 West Lake Lansing Road, Suite 700 I East Lansing, MI 48823
P (517) 853-7500 I F (517) 853-0142

email: contactus@eastlansingpodiatry.com
web: www.eastlansingpodiatry.com

Date of Appointment:__________________

PATIENT INFORMATION

Patient Name:____
(Last) (First) (M.I.) (Prefix/Suffix)

Address:____

City:______________________ State:__________ ZIP Code:______________

Date of Birth:__________ SSN: ______________ ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced

Home Phone:________________ Work Phone:________________ Cell Phone:________________

Preferred Method of Contact: ☐ Home ☐ Work ☐ Cell

Referred by:______________________ Primary Physician:______________________

Ethnicity: ☐ Caucasian ☐ Black/African American ☐ Hispanic/Latin American ☐ Asian

Other:______________________

Language Spoken at Home: ☐ English ☐ Spanish Other:______________________

GUARANTOR/GUARDIAN INFORMATION

Parent / Guardian Name, if Patient is Minor______________________________

Relationship to Patient:______________________________

Address:______________________________

City:______________________ State:__________ ZIP Code:______________

Home Phone Number:________________ Cell/Work Number:________________

EMERGENCY CONTACT INFORMATION

Person to Contact in Case of Emergency:______________________________

Relationship to Patient:______________________________

Address:______________________________

City:______________________ State:__________ ZIP Code:______________

Home Phone Number:________________ Cell/Work Number:________________

I hereby give permission to Dr. Papson to treat and/or photograph my feet.

______________________________ Date:______________
(Signature of Patient)

______________________________ Date:______________
(Signature of Parent/Guardian)

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Patient Name:_________________________________ Date of Birth:____________

MEDICAL HISTORY

Indicate with an "x" any conditions for which you have been or are currently being treated.

AIDS/HIV	☐	Ear Problems	☐	Osteoporosis	☐
Anemia	☐	Emphysema	☐	Phlebitis / Blood Clots	☐
Angina / Chest Pain	☐	Epilepsy/Seizures	☐	Polio	☐
Arthritis	☐	Eye Diseases	☐	Psychiatric Care	☐
Artificial Heart Valve	☐	Fainting/Light headed	☐	Respiratory Disease	☐
Artificial Joint	☐	Foot or Leg Cramps	☐	Shortness of Breath	☐
Asthma	☐	Gout	☐	Sinus Problems	☐
Back Problems	☐	Headaches	☐	Stroke	☐
Bleeding Disorders	☐	Heart Disease	☐	Swelling (Feet / Ankles)	☐
Cancer	☐	Hepatitis/Jaundice	☐	Thyroid Disorder	☐
Chemical Dependency	☐	High Blood Pressure	☐	Tuberculosis	☐
Chronic Diarrhea	☐	Kidney Disease	☐	Ulcers (Stomach)	☐
Circulation Problems	☐	Liver Disease	☐	Ulcers (Open Wounds)	☐
Diabetes Type 1	☐	Low Blood Pressure	☐	Varicose Veins	☐
Diabetes Type 2	☐	Neuropathy/Numbness	☐	Weight Loss	☐

Are you currently pregnant? ☐ Yes ☐ No Other:______________________________

Please list any medications you are currently taking, including dosage:

____

____

____

____

Allergies: Penicillin ☐ Sulfa ☐ Iodine ☐
Local Anesthetics ☐ Adhesives ☐ Shellfish ☐
No Known Allergies ☐

Other:______________________________

____

Reaction:______________________________

____

Previous foot conditions you have been treated for:

____

____

____

Previous foot surgeries: Neuroma ☐ Bunion ☐
Hammertoe ☐ Heel Spur ☐ Plantar Fascia ☐

Other:______________________________

____

____

Please list <u>any</u> other surgeries you have had:

____

____

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Patient Name:_________________________________ **Date of Birth:**____________

SOCIAL HISTORY

What is your occupation:____

Does your job involve: Sitting ☐ Standing ☐ Walking ☐ Climbing Ladders ☐

Smoking history: Never smoked ☐ Smoke less than 1 pack a day ☐ Smoke 1-2 packs a day ☐
Quit smoking ☐ Date quit smoking:______________ Smoking history unknown ☐

Alcohol Consumption: 1-2 Drinks a day ☐ More than 2 drinks a day ☐ 1-2-Drinks a week ☐
1-2 Drinks a month ☐ 1-2 Drinks a year ☐ Never ☐

Would you describe your diet as: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Do you exercise: Regularly ☐ Occasionally ☐ Rarely ☐ Never ☐

FAMILY HISTORY

Father: Living ☐ Current health: Good ☐ Fair ☐ Poor☐

Deceased ☐ Cause of death:___________________________

Mother: Living ☐ Current health: Good ☐ Fair ☐ Poor ☐

Deceased ☐ Cause of death:___________________________

Is there a family history of:

		Relationship			Relationship
Bleeding Disorders	☐	____________________	High Blood Pressure	☐	__________________
Diabetes	☐	____________________	Kidney Disease	☐	__________________
Heart Disease	☐	____________________			

Cancer (Describe type and relationship):____

____

Podiatric family history:

Bunions	☐	____________________	Flat Feet	☐	____________________
Hammertoes	☐	____________________	High Arches	☐	____________________