STEVEN A KULIK JR., MD
Board Certified Orthopaedic Foot & Ankle Surgeon

GBMC

MEDICAL HISTORY

(Please Print)
Patient name:__ _____ DOB:_____ AGE:_____
Height_____ Weight_____

Reason for visit:_____

SEVERITY OF PAIN: In general, what is the intensity of your pain (*circle one*)?

No Pain 0 1 2 3 4 5 6 7 8 9 10 ***Worse Possible Pain***

Referring Physician:_____ Phone #_____

Medical history: (circle all that apply and please specify)

Heart disease _____	Asthma	Arthritis
Blood Pressure Problems	Bronchitis	Systemic Erythema Lupus
Peripheral Vascular Disease	Bleeding Problems	Cancer _____
Kidney/Bladder Problems	Anemia	MRSA
Liver Problems	Diabetes type I / II	Frequent Infections
Lung Disease	Gastrointestinal	Hepatitis B, C, D, E, A
Scarlet Fever	Osteoporosis	HIV
Rheumatic Fever	Gout	Other _____
Polio	Rheumatoid Arthritis	

Past surgeries (please include date) :_____
_____
_____

Allergies: Penicillin/Sulfa/Latex/Iodine/
Shellfish/Contrast dye/Anesthesia
Type of Reaction:_____

Medications (dose and frequency):
(if unknown fax list to **443-444-4752**)
_____
_____
_____
_____

Family History: (circle all that apply and please specify)
Cancer _____ Heart Disease_____ Diabetes Type I, II Bleeding Disorder_____
Other:_____

Do You:
Smoke (cigars/cigarettes):_____ Packs per day:_____ How long:_____yrs Chew/Dip tobacco:_____
Drink alcohol (wine/beer/liquor):_____How often:_____
Have you ever had problems with substance abuse: Yes:_____ No:_____ Type of Substance _____

Review of Systems (please specify duration, quality):

Weight Change	Constipation/diarrhea	Depression
Temperature Changes	Bleeding irregularity	Nervousness
Bronchitis	Incontinence	Dizziness/Fainting
Chest Pain	Rashes	Other_____
Heart Palpitations	Skin Color Changes	
Heart Murmur	Infection	
Shortness of Breath	Ulcer	
Pneumonia	Headache	

Steven A. Kulik, Jr., M.D.
Foot & Ankle Surgery

Medstar Good Samaritan Hospital
5601 Loch Raven Blvd,
Smyth Bldg., Suite G-1
Baltimore, Maryland 21239
443-444-4230 Fax 443-444-4752

MedStar Orthopaedics

New Foot & Ankle Patient Questionnaire

Date: _____ Orthopaedic Surgeon: _____

Patient's Name: _____ GENDER: ❒ Female ❒ Male
(Last) (First) (MI)

Social Security #:_____ Birth Date:_____ Race:_____ Hispanic/Latino?: Yes No
(Please Circle)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Language:_____

Patient's E-mail: _____ ❒ Married ❒ Single ❒ Widowed

Employer: _____ Occupation: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone Number: _____

(Please do not leave the following fields blank.)

Referring Physician Name: _____

Phone Number: _____ Fax Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician Name: _____

Phone Number: _____ Fax Number: _____

Address: _____ City: _____ State: _____ Zip: _____

How did you hear about us?

❒ Physician ❒ Seminar ❒ Newspaper ❒ Television ❒ Friend/Relative

❒ Internet ❒ Our Website ❒ Google ❒ Other _____

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Dear Patients and Family Members:

Due to rising costs, we have instituted a policy to charge a fee of $25.00 per form/letter. This fee applies to the following:

Disability forms
FMLA forms
Home and Hospital Teaching forms

The advance fee of $25.00, payable in cash, check, or charge, is required to process any of the forms. Checks should be made payable to the Department of Orthopaedic Surgery and mailed or dropped off to our office. All forms will be completed within **10** days of receiving payment (**No exceptions**). Patients will be responsible to pick up their forms once completed. As a courtesy to our surgical patients, the first work disability form following the surgery will be completed at no charge, per surgery. Update forms will be on a work note. If additional forms are required from your employer the $25.00 fee will be assessed. All non – surgical patients will receive a work note. The office will not complete long term disability forms. If you have any questions, please do not hesitate to contact our office at 443-444-4230.

Thank You,

Steven A. Kulik, Jr., M.D.

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Referral Policy

If your Insurance Company requires that you provide us with a referral for treatment, please bring it with you at the time of your visit. You may have your Primary Care Physician fax the referral to our office; however, you are still required to bring a copy with you in order to be seen. It is your responsibility to find out if a referral is required!

If you do not have your referral at the time of your visit, you may be asked to either:

- Reschedule your appointment, or
- Pay out-of-pocket using cash, check or charge card

We apologize for any inconvenience this may cause.