Martin J. Faasse, D.P.M., P. C.

www.grandvillefootcare.com

Medical and Surgical Foot Specialist · Diplomate, American Board of Podiatric Surgery · Board Certified in Foot Surgery

History and Registration Form: Please fill out form completely.

Patient's Name: ______________________________ Spouse: ____________________

Address: ____
Street City State Zip

Cell: __________ Home: __________ Work: __________ Email: ____________________

Birth date: __________ Age: ________ Marital Status: ____________ Sex: ☐ Male ☐ Female

Guardian's Name (If patient is a minor): ____

Guardian's Address: ____

Patient's Occupation: ______________________________ Employer: ____________________

Patient's Social Security Number: ______________________ Spouse's Employer: ______________

Emergency Contact: __________________ Relationship: ______________ Phone: ______________

Whom may we thank for referring you to our office? ________________________________

Have you had or been treated for:

- ☐ Corns/Calluses
- ☐ Cramps in legs/feet
- ☐ Warts
- ☐ Bunions
- ☐ Rash
- ☐ Ankle Sprain
- ☐ Toe Walking
- ☐ Broken ankle
- ☐ Leg or Foot Ulcers
- ☐ Lower back pain
- ☐ Fungal Nails
- ☐ Arch Pain
- ☐ Athlete's Foot
- ☐ Flat Feet
- ☐ Hammer/Mallet toes
- ☐ Foot numbness
- ☐ Broken foot bone(s)
- ☐ Gait Problems
- ☐ Neuroma
- ☐ Knee pain
- ☐ Ingrown nails
- ☐ High arch feet
- ☐ Childhood foot problems
- ☐ Heel pain
- ☐ In-toeing
- ☐ None

What is your foot problem? ____

When did this start: ____

Have you treated this problem at home? ☐ Yes ☐ No If yes, how? ______________________

Have you had foot treatment before? ☐ Yes ☐ No If yes, by whom? ______________________

Your height: ______________ Your weight: ______________ Shoe size: ______________

Are you in: ☐ Good health ☐ Fair Health ☐ Poor Health

Are you subject to prolonged bleeding and/or healing difficulties? ☐ Yes ☐ No

Family Physician: ____

Please complete other side.

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Are you under the care of a doctor now? ☐ Yes ☐ No If yes, why?______________________________

Which doctor is currently caring for you? ____

Do you smoke? ☐ Yes ☐ No If yes, how many per day? ______________________________

Are you pregnant? ☐ Yes ☐ No If yes, when is your due date? ___________________________

What medications are currently taking? ____

____

____

____

I am allergic to:

- ☐ Antihistamines
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Iodine
- ☐ Latex
- ☐ Novocain
- ☐ Nylon/Plastics
- ☐ Penicillin
- ☐ Sulfa
- ☐ Sutures
- ☐ Tape Adhesives
- ☐ Other: ______________________________

____

____

☐ **I am not allergic to anything to my knowledge.**

I have or have had the following:

- ☐ Diabetes
- ☐ Arthritis
- ☐ Phlebitis
- ☐ Gout
- ☐ CVA
- ☐ Back Problems
- ☐ Leg Cramps
- ☐ Anemia
- ☐ Cancer
- ☐ Stroke
- ☐ Hip Problems
- ☐ Varicose Veins
- ☐ Kidney Disease
- ☐ Hypertension
- ☐ Heart Trouble
- ☐ Knee Problems
- ☐ Circulation Problem
- ☐ Bleeding Tendencies
- ☐ Difficulty Swallowing
- ☐ Asthma

If you are not diabetic, are you aware of any family member who had or has it? ☐ Yes ☐ No

If yes, what relation to you? ____

Past Surgeries and hospitalizations: ____

Is there anything else we should know? ____

Patient Representative: ___________________________ Relationship: _______________ Phone #: _________________

(Whom may we share your protected health information with, if anyone?)

This information is correct to the best of my knowledge:

_______________________________ _______________________________

Patient Signature Date

_______________________________ _______________________________

Guardian Signature (If patient is a minor) Relationship

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