Grandville Foot and Ankle, P.C.
Sarah Stewart, D.P.M.

Medical and Surgical Foot and Ankle Specialist · Diplomate, American Board of Podiatric Medicine

History and Registration Form: Please fill out form completely.

Patient's FULL Name: _____

Birth date: _____ Age: _____ Marital Status: _____ Sex: ☐ Male ☐ Female ☐ Other

Height: _____ Weight: _____ Shoe size and width: _____ Occupation: _____

Cell #: _____ Home #: _____ Work #: _____ Email: _____

We will make copies of your insurance cards and photo ID at your first patient visit, please bring them with you.

POWER OF ATTORNEY CONTACT INFORMATION:

Legal Power of Attorney Name:_____ Relationship to patient? _____

Address: _____
Street City State Zip

Cell:_____ Home: _____ Work: _____ Email: _____

BILLING ADDRESS:

Person responsible for paying bill: _____ Relationship to patient? _____

Mailing Address: _____
Street City State Zip

Contact phone number with area code: _____(home) _____(cell)

Emergency Contacts: _____ Relationship: _____ Phone: _____

Emergency Contacts: _____ Relationship: _____ Phone: _____

FAMILY MEDICAL HISTORY:

Past medical history of mother? _____; alive / deceased (date:_____)

Past medical history of father? _____; alive / deceased (date:_____)

Past medical history of sisters/brothers? _____; alive / deceased (date:_____)

Past medical history of children? _____; alive / deceased (date:_____)

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What is your foot problem? _____

When did this start: _____ **Is it getting worse or better?** _____

Describe the problem/pain: _____

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

Has the patient ever seen a foot or ankle specialist before? ☐ Yes ☐ No If yes, by whom? _____

Has the patient ever seen a vascular (blood flow) doctor before? ☐ Yes ☐ No If yes, by whom? _____

Is the patient subject to prolonged bleeding and/or healing difficulties? ☐ Yes ☐ No

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Do you use tobacco products? ☐ Yes ☐ No
How many packs per day to you use? _____

Do you use alcohol products? ☐ Yes ☐ No How many beers/glasses do you drink per day? _____

What type of alcohol products do you use? _____

Have you ever done rehabilitation for alcohol abuse? ☐ Yes ☐ No

Do you use any illegal drugs or substances? ☐ Yes ☐ No If yes, what types/how often: _____

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

Anything you have ever been diagnosed with or treated for? (Check all that apply)

____ High Blood Pressure	____ Heart Disease	____ MI (heart attack)	____ Heart Murmur
____ Stroke (CVA)	____ DVT/PE	____ Vascular Disease	____ Anemia
____ High Cholesterol	____ Kidney Disease	____ **Hypo**thyroidism	____ **Hyper**thyroidism
____ Liver Disease	____ IBS	____ Skin cancer	____ Tuberculosis
____ Chronic Back Pain	____ **Type 1** Diabetes	____ **Type 2** Diabetes (common)	____ **Gestational** Diabetes
____ Neuropathy	____ COPD	____ Sleep apnea	____ BPH
____ Asthma	____ Psoriatic Arthritis	____ Rheumatoid arthritis	____ Osteoarthritis (common)

Medication List with Doses & why you are taking it:

_____ _____ _____

_____ _____ _____

_____ _____ _____

What is your pharmacy/location: _____

3550 Fairlanes, SW PO Box 164 Grandville, MI 49468-0164 P: (616) 534-3920 F: (616) 534-0801

(back side, please flip over) 2

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ALLERGIES ***(check all that apply)****:* please write the adverse reaction you have when allergy is used next to allergy

☐ Antihistamines	☐ Novocain	☐ Tape Adhesives
☐ Aspirin	☐ Nylon/Plastics	☐ **Others**?
☐ Codeine	☐ Penicillin	_____
☐ Demerol	☐ Sulfa	
☐ Iodine	☐ Sutures	_____
☐ Latex	☐ Shellfish	

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

Past Surgeries and/or hospitalizations (include dates): _____

_____

Any foot or ankle surgeries (include dates)? _____

Any balance problems or frequent falls? (include dates): _____

Review of Systems: Please **CIRCLE** all that apply today (please let us know if any are ACUTE, or if these are not new symptoms and are chronic/ongoing problems.

CHILLS	FATIGUE	FEVER	WEAKNESS
NEW WEIGHT GAIN	NEW WEIGHT LOSS	CHEST TIGHTNESS	COUGH
SHORTNESS OF BREATH	WHEEZING	CONSTIPATION	DIARRHEA
HEART BURN	NAUSEA	VOMITTING	DEPRESSION
DISORIENTATION	MEMORY LOSS	CHARCOT	NUMBNESS
FOOT DROP	SPEECH DISORDER	HISTORY OF STROKE	TREMORS
ANEMIA	PAIN IN FOOT/ANKLE	PAIN IN LEG	BACK PAIN

CURRENT CHEMOTHERAPY

Is there anything else that is important for me to know? _____

WHO IS YOUR PCP? _____

This information is correct to the best of my knowledge:

_____ _____
Patient Signature Date

_____ _____
Guardian Signature (If patient is a minor) Relationship