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 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: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you find out about us (google, doctor referral, current patient referral)? _____

Have you had OR been treated for: (check any that apply)

_____ Corns/Calluses	_____ Ulcers/wounds	_____ Neuropathy	_____Neuroma
_____ High Arches	_____ Low Arches/Flatfeet	_____ Arch Pain	_____Heel Pain
_____ In-toeing	_____Pediatric Foot Problems	_____ Warts	_____ Broken Foot/Ankle
_____ Ingrown Toenails	_____ Fungal Nails	_____ Athlete's Foot	_____ Foot Rash
_____ Lower Back Pain	_____ Cramps in legs feet	_____ Inability to walk over 1 block	
_____ Bunions	_____ Hammertoes	_____ Muscle weakness	

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? _____

Have you ever seen a foot or ankle specialist 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: _____

Have you ever seen a vascular (blood flow) doctor before? _____ If so, who? _____

Have you ever seen any other specialist doctors before? _____ If so, who? _____

Please complete other side.

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

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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	____ Diabetes, **Type 1**	____ Diabetes, **Type 2**	____ Diabetes, **Gestational**
____ Neuropathy	____ COPD	____ Sleep apnea	____ BPH
____ Asthma	____ Psoriatic Arthritis	____ Rheumatoid arthritis	____ Osteoarthritis
____ Osteoporosis	____ Alzhiemers Disease	____ Dementia	____ Tuberculosis

Others? _____

Medication List with Doses: _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

What is your pharmacy/location: _____

May we request your medication list from your pharmacy and send prescriptions electronically to your pharmacy, if it is available and possible to do so? **YES** or **NO**

ALLERGIES *(check all that apply):* please write your reaction next to allergy (i.e. rash, shortness of breath, fainting, etc)

☐ 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 hospitalizations (year): _____

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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