

Grandville Foot and Ankle, P.C.
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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)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Corns/Calluses | <input type="checkbox"/> Ulcers/wounds | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Neuroma |
| <input type="checkbox"/> High Arches | <input type="checkbox"/> Low Arches/Flatfeet | <input type="checkbox"/> Arch Pain | <input type="checkbox"/> Heel Pain |
| <input type="checkbox"/> In-toeing | <input type="checkbox"/> Pediatric Foot Problems | <input type="checkbox"/> Warts | <input type="checkbox"/> Broken Foot/Ankle |
| <input type="checkbox"/> Ingrown Toenails | <input type="checkbox"/> Fungal Nails | <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Foot Rash |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Cramps in legs feet | <input type="checkbox"/> Inability to walk over 1 block | |
| <input type="checkbox"/> Bunions | <input type="checkbox"/> Hammertoes | <input type="checkbox"/> 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.

