

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

Medical and Surgical Foot and Ankle Specialist · Diplomat, 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: _____

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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

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)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> MI (heart attack) | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Stroke (CVA) | <input type="checkbox"/> DVT/PE | <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> IBS | <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Type 1 Diabetes | <input type="checkbox"/> Type 2 Diabetes (common) | <input type="checkbox"/> Gestational Diabetes |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> COPD | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> BPH |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Psoriatic Arthritis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Osteoarthritis (common) |

Medication List with Doses & why you are taking it:

_____	_____	_____
_____	_____	_____
_____	_____	_____

What is your pharmacy/location: _____

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Novocain | <input type="checkbox"/> Tape Adhesives |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Nylon/Plastics | <input type="checkbox"/> Others? |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | _____ |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Sulfa | _____ |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Sutures | |
| <input type="checkbox"/> Latex | <input type="checkbox"/> 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