Grandville Foot and Ankle

Dr. Sarah Stewart, DPM

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

History and Registration Form:

Patient's FULL Name: _____

Birth date: _____ 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.

BILLING ADDRESS:

Person responsible for paying bill if not the patient: _____ 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: _____

POWER OF ATTORNEY CONTACT INFORMATION*: (if applicable)*

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

Address: _____
Street City State Zip

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

What is your pharmacy/location: _____ **WHO IS YOUR PCP?** _____

Grandville Foot and Ankle, P.C.
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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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Are you pregnant? ☐ Yes ☐ No If yes, when is your due date? _____

Are you currently being treated with chemotherapy? ☐ Yes ☐ No If yes, why? _____

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? ☐ liquor ☐ Beer ☐ Wine

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: _____

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: (please skip, if you have your medication list with you)

_____ _____ _____

_____ _____ _____

_____ _____ _____

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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): _____

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

_____

This information is correct to the best of my knowledge:

_____ _____
Patient Signature Date

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