Grand Traverse Foot & Ankle Center PC

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Diplomate, American Board of Podiatric Surgery & Certified in Foot Surgery

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PATIENT INFORMATION (CONFIDENTIAL – PLEASE PRINT)

Last Name: _____ First: _____ Middle: _____

Street Address: _____ City/State: _____ Zip: _____

P.O. Box: _____ Email: _____

Phone #: (____) _____ Cell: (____) _____ Birthdate: ____-____-____ Age: _____

Sex: ❑ M ❑ F Social Security #: ____-____-____ ❑ Married ❑ Single ❑ Widowed

Employer: _____ Work Phone: (____) _____

Emergency Contact Name: _____ Phone: (____) _____ Relationship: _____

For minor child, who is responsible for bill? (❑ Parent ❑ Guardian):

Last Name: _____ Name (First, Middle): _____

Street Address: _____ City/State: _____ Zip: _____

Phone #: (____) _____ Social Security #: ____-____-____ Birthdate: ____-____-____

Employer: _____ Work Phone: (____) _____

Street Address: _____ City/State: _____ Zip: _____

INSURANCE

Policyholder/Spouse: _____ Social Security #: ____-____-____ Birthdate: ____-____-____

Primary Insurance Company: _____

Secondary Insurance Company: _____

Is this a work comp claim? _____

MEDICAL

How did you hear about our office? _____

What foot problem are you having? _____

_____

When did this problem begin? _____

Have you had previous foot care? _____

Your: Height: _____ Weight: _____ Shoe Size: _____

Name of family physician: _____ Date of last physical: ____/____/____

List medication that you are currently taking: Pharmacy: _____

See attached list of medications ❑ Do you take any blood thinners? ❑ Yes ❑ No

List of Medications	**List of Medications**

Continued on Back

FAMILY HISTORY

	SELF	FATHER	MOTHER	SIBLING		SELF	FATHER	MOTHER	SIBLING
AGE (IF LIVING)					EPILEPSY				
HEALTH (G) GOOD (B) BAD					NERVOUSNESS				
CANCER					ASTHMA, HIVES, HAYFEVER				
DIABETES					BLOOD DISEASE				
HEART TROUBLE					AGE (AT DEATH)				
GOUT					CAUSE OF DEATH				
STROKE									

PERSONAL HISTORY

HAVE YOU EVER HAD…	YES	NO	HAVE YOU EVER HAD…	YES	NO	HAVE YOU EVER HAD…	YES	NO
SCARLET FEVER			ANEMIA			ANY ❑ BROKEN ❑ CRACKED BONES		
PNEUMONIA			VARICOSE VEINS			RECURRENT DISLOCATIONS		
RHEUMATIC FEVER			KIDNEY DISEASE			SPRAINS		
❑ ARTHRITIS ❑ RHEUMATISM			MIGRAINE HEADACHES			ARE YOU CURRENTLY PREGNANT?		
ANY ❑ BONE ❑ JOINT DISEASE			TUBERCULOSIS			CURRENTLY NURSING		
❑ NEURITIS ❑ NEURALGIA			STOMACH TROUBLE					
❑ BURSISTIS ❑ SCIATICA ❑ LUMBAGO			ULCERS			HAVE TESTED HIV POSITIVE		
❑ POLIO ❑ MENINGITIS			LIVER DISEASE			EXPLAIN:		
LOWER BACK PAIN			LEG CRAMPS					
GLAUCOMA			ECZEMA					
VASCULAR DISEASE			THYROID DISEASE					

ALLERGIES

LIST ANY CURRENT ALLERGIES

SURGERY

HAVE YOU EVER HAD…	YES	NO	HAVE YOU EVER HAD…	YES	NO	HAVE YOU EVER HAD…	YES	NO
FOOT/ANKLE SURGERY			BEEN HOSPITALIZED FOR ANY ILLNESS			HAD ANY RECENT OPERATIONS		
EXPLAIN:			EXPLAIN:			EXPLAIN:		

HABITS

DO YOU USE…	NEVER	OCC.	FREQ.	DAILY	DO YOU…	YES	NO
ALCOHOLIC BEVERAGE					PARTICIPATE IN SPORTS		
CAFFEINE					**HAVE YOU EVER…**		
TOBACCO: ❑ CIGARETTES (PKS PER DAY)					BEEN TREATED FOR ALCOHOLISM		
❑ CIGARS ❑ PIPE ❑ CHEWING TOBACCO					BEEN TREATED FOR DRUG ABUSE		

Signature _____ Date _____

Thank you for choosing our office.