Ronald K. Olm, D.P.M., FACFAS, C.Ped
Diplomate, American Board of Podiatric Surgery & Certified in Foot Surgery

4246 N. Three Mile Rd. • Traverse City MI 49686
(231) 922-9100 • www.gtfootanklecenter.com

PATIENT INFORMATION (CONFIDENTIAL – PLEASE PRINT)

Last Name: ______ First: ______ Middle: ______
Street Address: ______ City/State: ______ Zip: ______
P.O. Box: ______ Email: ______
Would you like to be Web Enabled? ❑ Yes ❑ No
Phone #: (____) ______ Cell: (____) ______ Birthdate: ____-____-____ Age: ______
Sex: ❑ M ❑ F ❑ Transgender 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? ______
Type of pain / location? ______
When did this problem begin? ______
Have you had previous foot care? ______
Your: Height: ______ Weight: ______ Shoe Size: ______
Name of Physician? ______ Date of last physical: ____/____/____
Name of Pharmacy? ______
How many falls have you had this year? ______ How many were injuries? ______

Flu shot: ❑ Yes ❑ No Date: ______ Pneumococcal vaccine: ❑ Yes ❑ No Date: ______

List medication that you are currently taking:

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

FAMILY HISTORY

	FATHER	MOTHER		FATHER	MOTHER
AGE (IF LIVING)			EPILEPSY		
HEALTH (G) GOOD (B) BAD			ASTHMA		
CANCER			BLOOD DISEASE		
DIABETES			AGE (AT DEATH)		
HEART TROUBLE			CAUSE OF DEATH		
GOUT					
STROKE					
COPD					

PERSONAL HISTORY

HAVE YOU EVER HAD…	YES	NO	HAVE YOU EVER HAD…	YES	NO	HAVE YOU EVER HAD…	YES	NO
PNEUMONIA			ANEMIA			ANY ❏ BROKEN ❏ CRACKED BONES		
RHEUMATIC FEVER			VARICOSE VEINS			RECURRENT DISLOCATIONS		
❏ ARTHRITIS ❏ RHEUMATISM			KIDNEY DISEASE			SPRAINS		
SEIZURES			MIGRAINE HEADACHES			ARE YOU CURRENTLY PREGNANT?		
❏ NEURITIS ❏ NEURALGIA			TUBERCULOSIS			CURRENTLY NURSING		
❏ BURSISTIS ❏ SCIATICA ❏ LUMBAGO			STOMACH TROUBLE			HAVE TESTED HIV POSITIVE		
❏ POLIO ❏ MENINGITIS			ULCERS			EXPLAIN:		
LOWER BACK PAIN			LIVER DISEASE					
CATARACTS			LEG CRAMPS			**HAVE YOU EVER HAD** MRSA?		
GLAUCOMA			ECZEMA			A STROKE?		
VASCULAR DISEASE			THYROID DISEASE			TREMORS?		
			HIGH CHOLESTEROL			DIABETES?		

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 OPERATIONS		
EXPLAIN:			EXPLAIN:			EXPLAIN:		

HABITS

DO YOU USE…	FORMER	NEVER	OCC.	FREQ.	DAILY	DO YOU…	YES	NO
ALCOHOLIC BEVERAGE						PARTICIPATE IN DAILY EXERCISE		
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.