X Gideon G Lewis MD (Family Practice) Gideon J Lewis DPM (Foot and Ankle)

**Welcome to** Drs. Lewis and Lewis MD PA.

**If you are a new patient or have not seen us for 3 years, please complete the following *6 page* health history prior to your appointment. Feel free to ask for assistance from the staff or your provider if you are unsure how to answer a question. Please print your answers.**

Date: _____

**LAST Name**:_____ **Title: _____**

**FIRST Name: _____** **Middle Initial: _____**

**Address**: _____

**City: _____** **State:_____** **Zip Code:_____**

**Sex (please circle):** M or F

**Social Security #: _____ Date of birth:____/___/_____**
D M Year

**Home phone**:_____**Work phone: _____**

**Cell Phone:_____Email address: _____**

**Primary Doctor: _____**
(First Name, Last Name)

**Referring Doctor: _____**
(First Name, Last Name)

**Marital Status** (please circle) : Single Married Divorced Widowed

**Student** (please circle): Full-Time Part-Time

**Preferred Method of Contact:** (please circle one) Cell Phone Home Phone

**Please state reason for today's visit**: _____

**Education:** ☐ middle school ☐ high school ☐ college degree ☐ post college degree

**Occupation/ Employer**: _____

**Spouse/partner Occupation** (spouse/partner): _____

**In Case of Emergency:**

Name: _____Phone: _____

Relationship: _____

**Do you have a "living will" or other advanced directive**

Y or N If yes, where is it filed? _____

If no, would you like information today? ☐Yes ☐ No if yes, date given:_____nurses initials _____

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# Insurance Information:

Date: _____

## Responsible Party/Primary Insurance Policy Holder Information

Last Name:_____ DOB: _____/_____/_____
D M Year

First Name: _____ Middle Initial: _____

Phone:_____ Sex: M F

Email address: _____

Relation to Patient: _____ Social Security #: _____

Employer:_____ Work Telephone: _____

## Insurance Plan Information:

*Primary Insurance Company*:_____ Effective Date: ____/_____/_____
D M Year

Plan (please circle): HMO PPO POS EPO

Member ID_____ Group #_____

Address:_____

City/State/Zip: _____ Policy Holder _____

*Secondary Insurance Company*:_____

Plan (please circle): HMO PPO POS EPO

Member ID_____ Group #_____

Address:_____

City/State/Zip: _____ Policy Holder _____

☐ Private Pay

_____ _____

(print) patient name

**Date:**

**Pharmacy Name**:_____**Phone Number**: _____

**Address**:_____

**Mail Order Pharmacy**: _____

**Member ID # for Rx:** _____

## Allergies to Medications

| Medication | Reaction |
|---|---|
| | |
| | |
| | |

**Current Medications** **(please include over the counter medications and food supplements)**

| Drug Name | Dose | How Often? | Drug Name | Dose | How Often? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Your Health History (Check if you have had any of the following)

- ☐ Abnormal Heart Rhythm
- ☐ Allergies/Seasonal/ Environmental
- ☐ Anemia
- ☐ Anxiety/Stress
- ☐ Asthma
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Back Pain
- ☐ Colitis or Crohn's Disease
- ☐ Cancer (Any type)
- ☐ Chronic Bronchitis
- ☐ Chronic Pain
- ☐ Chronic Kidney Disease
- ☐ Depression
- ☐ DiabetesDiverticulitis
- ☐ Emphysema/COPD
- ☐ Gall Bladder Disease
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ Heartburn (GERD)
- ☐
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ IBS
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Mental Illness
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Peripheral Vascular Disease
- ☐ Seizures/Epilepsy
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Urinary Tract Infection

_____

_____
(print) patient name

**Please list any hospitalizations and surgeries with approximate dates:**

_____

_____

_____

Have you had blood transfusions: ☐ Yes or ☐ No

How many hours a night do you sleep? _____

Any trouble falling asleep? ☐ Yes ☐ No

Any trouble staying asleep? ☐ Yes ☐ No

Have you been told you snore loudly? ☐ Yes ☐ No If so, do you fall asleep easily during the day? _____

In the past 7 days, how many times have you used an over-the-counter or prescription sleep aid? _____

_____ _____

(print) patient name

## Preventive Health History

Check if you have had any of the following and provide date (month and year and/or results)

| | | Date | Results |
|---|---|---|---|
| ☐ | Colonoscopy | _____ | _____ |
| ☐ | Cardiac Stress Test | _____ | _____ |
| ☐ | Mammogram | _____ | _____ |
| ☐ | Bone Density | _____ | _____ |
| ☐ | Pelvic and Pap | _____ | _____ |
| ☐ | Cholesterol Screening | _____ | _____ |
| ☐ | Prostate Antigen Test (PSA) | _____ | _____ |

| | **Vaccines** | Date |
|---|---|---|
| ☐ | Tetanus (Td or Tdap) | _____ |
| ☐ | Pneumonia | _____ |
| ☐ | Zostavax (Shingles) | _____ |
| ☐ | Hepatitis B | _____ |
| ☐ | Influenza (flu) | _____ |

Have you traveled or are you planning a visit outside of the United States? ☐ Yes ☐ No

If yes, list locations and dates: _____

Is medical information presented to you in an easy to understand manner?
☐ Never ☐ Occasionally ☐ Sometimes ☐ Always

How often are medical forms difficult to understand and fill out? ☐ Never ☐ Occasionally ☐ Sometimes ☐ Always

How often do you have problems learning about your medical condition because of difficulty understanding written information? ☐ Never ☐ Occasionally ☐ Sometimes ☐ Always

What are your hobbies? _____

How would you rate your diet? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any food allergies or intolerance? ☐ Yes ☐ No
Specify: _____

Do you follow a special diet or nutrition plan? ☐ Yes ☐ No
Specify: _____

Tobacco use: Smoking history: ☐ Never smoked ☐ Started (age) ___ ☐ Stopped (age) _____
How many packs per day do you now smoke now _____ in the past _____

Do you dip or chew tobacco? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No
If yes, please estimate how much you drink: _____ Glasses/cans per day/week/month (circle one)

Have you ever had a drinking problem? ☐ Yes ☐ No When was your last drink? _____

How many cups of coffee, tea, or other caffeine products (like Coke) do you drink daily? _____

Do you use, or have you used marijuana, cocaine, IV drugs, or other street drugs? ☐ Yes ☐ No

Do you consider yourself the appropriate weight? ☐ Yes ☐ No

_____ _____
(print) patient name

If No, what do you think an appropriate weight would be for you? _____

Describe your regular physical activity or exercise program:
Type:_____
Frequency:_____days per week Duration:_____minutes
Intensity: ☐ Low ☐ Moderate ☐ High

Do you see a dentist? ☐Yes ☐ No Last visit date: _____

Do you see an eye doctor? ☐ Yes ☐ No Last visit date: _____

How often do you wear seat belts? ☐ Always ☐ Occasionally ☐ Never

Were you adopted? ☐ Yes ☐ No if no, complete the following table:

**Family History**

| | Mother | Father | Maternal Grandparents | Paternal Grandparents | Brother | Brother | Sister | Sister |
|---|---|---|---|---|---|---|---|---|
| Breast Cancer | | | | | | | | |
| Colon Cancer | | | | | | | | |
| Diabetes | | | | | | | | |
| Heart Attack | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| High Cholesterol | | | | | | | | |
| Lung Cancer | | | | | | | | |
| Prostate Cancer | | | | | | | | |
| Skin Cancers | | | | | | | | |
| Stroke | | | | | | | | |
| Other (Please Specify): | | | | | | | | |

If your mother, father, brothers or sisters are deceased, please list their age at the time of death and the cause:

_____

_____

How do you rate your overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please check any of the following that apply to you:

YES NO
____ ____History of STI's (sexually transmitted infections):
(HPV, genital warts, chlamydia, herpes, gonorrhea, syphilis, other_____)
____ ____Have you ever been tested for HIV disease?
If Yes, what year? _____
If No, would you like to be tested? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No Age of first sexual encounter (intercourse) _____
If yes: Are your sexual partners ☐ Male ☐ Female ☐ Both

_____ _____

(print) patient name

YES NO

____ ____Do you feel safe in your current relationship?

____ ____Do you feel afraid of a partner/spouse?

____ ____Have you ever, or are you currently suffering abuse (slapping, hitting, choking, yelling, threatened) in your relationship? If Yes: _____

____ ____Are your friends and family aware of any problems/abuse in your relationship?

____ ____Do you have an emergency escape plan and somewhere safe to go?

Over the past 2 weeks, how often have you been bothered by any of the following problems:

Little interest or pleasure in doing things

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

Feeling down, depressed or hopeless

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

## Systems Review

Please check any of the following that you have experienced or are a concern to you

**Constitutional**

- Weight Gain/Loss ☐
- Fatigue ☐
- Fever or Sweats ☐
- Headache ☐

**Eyes**

- Glasses/Contacts ☐
- Cataracts ☐
- Double Vision ☐
- Glaucoma ☐

**Ears.Nose.Throat**

- Difficulty Hearing ☐
- Ringing in Ears ☐
- Vertigo ☐
- Sinus Pain ☐
- Nasal Congestion ☐
- Frequent Sore Throats ☐
- Hoarseness ☐

**Cardiovascular**

- Chest Pain ☐
- Palpitations ☐
- Fainting Spells ☐
- Dizziness ☐
- Difficulty Lying Flat ☐
- Swelling in Legs ☐
- Cramps, Coldness in Legs ☐

**Respiratory**

- Cough ☐
- Coughing Blood ☐
- Wheezing ☐
- Shortness of Breath ☐

**Gastrointestinal**

- Heartburn ☐
- Nausea/Vomiting ☐
- Constipation ☐
- Diarrhea ☐
- Difficulty Swallowing ☐
- Abdominal Pain ☐
- Black Stools ☐

**Genitourinary**

- Frequent Urination ☐
- Difficult Urination ☐
- Burning on Urination ☐
- Nightime Frequency ☐
- Blood in Urine ☐
- Abnormal Discharge ☐
- Genital Skin Lesions ☐

**Endocrine**

- Loss of Hair ☐
- Heat/Cold Intolerance ☐
- Weight Gain ☐
- Sexual Dysfunction ☐

**Lymph/Immune**

- Easy Bruising ☐
- Gums Bleed Easily ☐
- Enlarged Glands ☐
- Hay Fever/Allergies ☐

**Musculoskeletal**

- Joint Pain.Swelling ☐
- Back Pain ☐
- Muscle Pain ☐

**Skin**

- Rash/Sores ☐
- Abnormal Moles ☐
- Abnormal Masses ☐

**Neurological**

- Weakness/Paralysis ☐
- Numbness ☐
- Tremors ☐
- Memory Loss ☐

**Psychiatric**

- Mood Swings ☐
- Difficulty Sleeping ☐
- Anxiety/Depression ☐

_____ _____

(print) patient name

**Women**

Vaginal discharge or infections ☐
Painful intercourse or sexual difficulty ☐
Abnormal bleeding ☐
Do you douche vaginally? ☐ If so, how often _____
Breast lump, pain or nipple discharge ☐
History of abnormal Pap Smears ☐

Date of first day of last menstrual period? _____
Age at first period? _____
Age at menopause? _____
Number of days of menstrual flow per cycle? _____
Flow (check one) ☐ Mild ☐ Moderate ☐ Heavy
Number of days between successive periods?
Number of pregnancies? _____
Number of Children? _____
History of female surgeries: ☐ Hysterectomy ☐ Tubes Tied ☐ D&C ☐ Other _____

**MEN**

Discharge from penis ☐
Lump or pain in testicles ☐
Problems with erections ☐
Decreased sex drive/desire ☐
Difficulty with urine stream ☐

Please list recent past physicians with address and specialty who have cared for you:

1. _____
2. _____
3. _____

Who completed this form? Patient ____ Relative ____ If so, what relationship? ____ Friend ____

_____ _____

Patient Signature Date

**THANK YOU for completing this 6 page Health History. It will help us provide YOU with better care.**

**Do <u>not</u> write below this line**

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I reviewed this patient's history form.

_____ _____

Health Care Provider's Signature Date