Foot and Ankle Sports Medicine Institute

Dr. Gideon J. Lewis

If you are a NEW PATIENT please complete the following pages.
(Patients who have not had an appointment in our office for over 3 years are considered NEW PATIENTS)

Date: _____

LAST Name:_____ **FIRST Name:** _____ **MIDDLE Initial:** _____

Address: _____

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

Date of birth: _____/_____/_____ **Social Security #:**_____-_____-_____ **Sex:** M F
M D Year

Marital Status (Circle): Single Married Divorced Widowed **Student** (Circle): Full-Time Part-Time

Home phone:_____ **Cell Phone:** _____

Occupation/ Employer:_____ **Work phone:** _____

Email address: _____ **Preferred Contact (**Circle)**: HOME CELL WORK**

Responsible Party/Primary Insurance Policy Holder Information ☐ **Private Pay**

LAST Name:_____ FIRST Name: _____ MIDDLE Initial: _____

DOB: _____/_____/_____ Sex: M F Phone:_____
M D Year

Relationship to Patient:_____ Employer:_____

Insurance Plan Information:

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

Plan (Circle): HMO PPO POS EPO

Secondary Insurance Company:_____ Plan (Circle): HMO PPO POS EPO

Primary Doctor: _____
(First Name, Last Name)

Referral Source: Website Friend Family Advertisement Phonebook Other_____

In Case of Emergency:

Name: _____ Phone: _____ Relationship: _____

Gideon J. Lewis, D.P.M., FACFAS

Date: _____ Patient Name:_____ Age:_____

Occupation: _____ **Height: _____ **Weight: _____

CHIEF COMPLAINT / PRESENT ILLNESS

What is your present foot/ankle/leg problem? _____

(circle) Right Foot Left Foot Right Ankle Left Ankle Right Leg Left Leg

If due to an injury, date and details? _____

_____

How long have you had this problem? (specify time) #_____ (circle) days weeks months years

Are you having pain? (circle) Yes No Pain Scale 1-10 (least to most severe) _____

Please describe your pain: (circle all that apply) Sharp Burning Tingling Dull/Aching Other:_____

Specific location of problem: _____

Associated Symptoms: _____

What have you done for your foot/ankle/leg problem?_____

_____

LOWER EXTREMITY MEDICAL HISTORY

What **Activities** or **Sports** do you participate in? _____

Shoe Size: _____ How many hours per day are you on your feet?_____

Have you had previous foot/ankle/leg care? (circle) Yes No If yes, by whom_____

Family with lower extremity problems similar to yours? (circle) Mother Father Siblings

Have you had **Previous Foot, Ankle, or Leg Surgery**? (circle) Yes No If yes, please list:

TYPE **DATE**

_____

_____

_____

Are there any **OTHER MEDICAL ISSUES** you would like to address?

_____

_____

MEDICAL HISTORY:

Have you had either of the following Shots? If yes, please list when & where (i.e. PCP, Walgreens, CVS, etc.)

****Flu Shot:_____ **Pneumonia Shot:_____**

ALLERGY to any medication(s)? (Please circle all that apply): *Adhesive* *Amoxicillin* *Aspirin*

Augmentin *Betadine* *Codeine* *Demerol* *Erythromycin* *Ibuprofen* *Iodine*

Keflex *Latex* *Morphine* *NSAIDs* *Penicillin* *Sulfa Drugs* *Tylenol*

Lidocaine *Antihistamines* *Other*_____ **N***o* **K***nown* **D***rug* **A***llergies*

LIST ALL CURRENT MEDICATIONS:_____

_____

_____

MEDICAL CONDITIONS: (Circle current and/or past medical conditions:)

AIDS/ARC	Bleeding tendency	Heart Disease	Mitral Valve Prolapse
Allergies	Cancer	Heart Murmur	Mental Health Conditions
Anemia	Diabetes	Hepatitis	Rheumatic Fever
Anesthesia Problems	Epilepsy	High Blood Pressure	Tuberculosis
Arthritis	Glaucoma	Kidney Disease	Ulcers
Asthma	Gout	Liver Trouble	Circulation Disorders
Stomach Ulcer	Polio	Venereal Disease	Leg Cramps
Previous Foot Condition	Stroke	Other_____	

Have you had **SURGERY (other than foot or ankle)**? (circle one) Yes No

TYPE OF SURGERY **DATE**

_____

_____

Have you had any **COMPLICATIONS** with **Anesthesia or Surgery**: Yes No If yes, please explain:

_____

SOCIAL HISTORY (Circle and/or fill out all that apply

Use of Alcohol: Never Rarely Moderate Daily

****Use of Tobacco:** Never Previously but quit Current packs/day_____

Use of Drugs: Never Type/frequency_____

FAMILY HISTORY ** (**Please list any family members who have had any of the following conditions**)

1. Arthritis_____ 3. Diabetes_____ 5. High Blood Pressure_____
2. Cancer_____ 4. Heart Disease_____ 6. Kidney Disease_____

****Required by US Government**