GIDEON G. LEWIS, M.D.

Date: _____

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

Address: _____

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

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

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 PHONE leave Message** **HOME PHONE don't leave a message**
CELL PHONE leave message **CELL PHONE don't leave a message**
WORK PHONE leave message **WORK PHONE don't leave a message**

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

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

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

Relationship to Patient: _____ Employer:_____

Insurance Plan Information:

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

Plan (Circle): HMO PPO POS EPO

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

Do you have a living will? Yes No If yes, where is it filed_____

Do you have an advanced directive? Yes No If yes, where is it filed_____

Referral Source: Website Friend Family Advertisement Phonebook Other_____

In Case of Emergency:

Name: _____ Phone: _____ Relationship: _____

Printed Patient Name:_____ **Patient Signature:**_____

Date:_____ **Patient Name:_____**

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

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 (PSA)	_____	_____

Vaccines

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

Date:_____ **Patient Name:**_____

Systems Review

Please circle 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/Contact
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
Night Time 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

Please list any hospitalizations and surgeries with approximate dates:

_____

_____

_____

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):								

Date:_____ **Patient Name:**_____

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

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: _____

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

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

1. _____
2. _____
3. _____

Who completed this form? Patient _____ Relative_____ Friend _____

Printed Patient Name:_____ **Patient Signature:**_____

Date:_____ **Patient Name:_____**

Pharmacy Name:_____ Phone Number:_____

Address:_____

Mail Order Pharmacy: _____

Member ID# for prescription: _____

Preferred Pharmacy for prescriptions:_____

****Please give a 24 hour notice for any appointment changes to avoid a missed appointment fee of $30.**