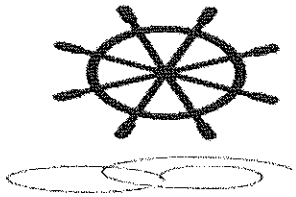

INTERNAL MEDICINE OF SOUTHWEST FLORIDA

Ernest Gesiotto, M.D.

Rob Simmons, M.D.

Diana Young, M.D.

New Patient

Registration Form

Date: _____

_____

Patient Name (Please Print – Last, First, Middle Initial)

_____

Address City, State, Zip

_____

Northern Address (If Applicable) City, State, Zip

_____ _____

Home Phone Cell Phone

Other Important Phone Numbers: _____

Date of Birth: _____ □ Male □ Female

Are you: □ Married □ Single □ Divorced □ Widowed

Email Address: _____

Emergency Contact – Name/Phone: _____

_____

Pharmacy Information

Preferred Pharmacy	Secondary Pharmacy
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

List any medications including dosages you now take (prescription and non-prescription, include vitamins and alternative therapy supplements)

Medication	Dosage

List medications/substances to which you are allergic:

□**No Known Allergies**	

List all hospitalizations/surgeries starting include the year and for what conditions:

Hospitalizations/Surgeries	**Year**

Please check if you have experienced any of the following conditions and year of onset.

	yes	year		yes	year
Allergies			Gout		
Anemia			Hepatitis/Liver Disease		
Benign Prostatic Hypertrophy			High Blood Pressure		
Anxiety			Hyperlipidemia		
Coronary Artery Disease			Irritable Bowel Disease		
Arthritis			Liver Disease		
Atrial Fibrillation			Migraine Headaches		
Blood Clots			Myocardial Infarction/Heart Attack		
Cancer			Osteoarthritis		
COPD/Emphysema			Osteoporosis		
Dementia/Alzheimer's			Peptic Ulcer Disease		
Depression			Renal/Kidney Disease		
Diabetes			Seizure Disorder		
Crohn's Disease			Sexually transmitted disease		
GERD (reflux)			Stroke/TIA		
Gallbladder Disease			Thyroid Disease		
Glaucoma					

Other:_____

_____

Family History: Please check if you have a family history of the following:

	Father	Mother	Brother	Sister	Other Family Member
Alcoholism					
Alzheimer's Disease					
Asthma					
Blood Disease					
Heart Disease					
Cancer					
Stroke					
Depression					
Diabetes					
High Blood Pressure					
Mental Illness					
Osteoarthritis					
Osteoporosis					
Renal/Kidney Disease					
Other_____					
Other_____					

Health Maintenance: Please fill in the date of any of the following exams/tests

Exam/Test	**Date**	**Exam/Test**	**Date**
Shingles/Zostavax Vaccine		Dexa/Bone Density	
Influenza Vaccine		Colonoscopy	
Pneumonia Vaccine		PAP Smear	
Tdap		Mammogram	
Hepatitis B		Date of last menstrual cycle	
EKG		PSA	
Chest x-ray		Prostate Screening	

Social History/Wellness/Prevention:

Occupation/Employer:
Do you have any Children: □ No □ Yes How Many? Male(s) Female(s)
Current Tobacco Use □ No □ Yes Year Quit_____ # Packs per week_____ □ Chewing □ Cigar □ Pipe □ Cigarette □ Vapor
How many alcohol beverages do you consume per week? _____ Type?_____
Do you drink caffeine? □ No □ Yes Average beverages per week?_____
Are you sexually active? □ No □ Yes
Do you drive? □ No □ Yes
Do you have a living will? □ No □ Yes If yes please provide us with a copy
Do you have a power of attorney? □ No □ Yes If yes please provide a copy Contact Information:_____
Do you use any assistive devices? □ No □ Yes If yes please provide details:_____
Who lives with you?_____
Do you have an alert system? □ No □ Yes
Do you having trouble hearing? □ No □ Yes If yes do you wear hearing aids? □ No □ Yes
Do you exercise regularly? □ No □ Yes If yes how often?_____ Type of exercise_____
Do you sleep well at night? □ No □ Yes

Any other concerns you wish to share with the doctor?_____

_____

_____

_____

_____