



A Lexington Medical Center Physician Practice

Patient History

Lexington Medical Park 1, 2728 Sunset Boulevard, Suite 104, West Columbia, SC 29169
Phone: (803) 791-2722 • Fax: (803) 791-2723



Patient Name: _____ Date: _____ Age: _____

Referring Physician: _____

Reason for Visit: _____

Operations and Dates: _____

MEDICAL PROBLEMS: (Check all)

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | COPD |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Atrial Fibrillation |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Congestive Heart Failure |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastroesophageal Reflux Disease (GERD) |
| <input type="checkbox"/> | <input type="checkbox"/> | Cataracts |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS/HIV |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer Type: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

IMPAIRMENTS:

- | YES | NO | |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Speech |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing |
| <input type="checkbox"/> | <input type="checkbox"/> | Seeing |
| <input type="checkbox"/> | <input type="checkbox"/> | Language (Requiring Interpreter) |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheelchair |

FAMILY MEDICAL HISTORY:

(heart disease, cancer, diabetes, etc.)

Father: _____

Mother: _____

Siblings: _____

Other: _____

OTHER SYMPTOMS: (Please check)

GENERAL:

- Poor appetite Night sweats Weight Loss Fever Chills

HEENT:

- Bleeding gums Nose bleeds Mouth ulcers or lesions
 Hoarseness Blurred Vision Ringing in Ears

CARDIAC:

- Angina Palpitations Irregular heartbeat Pacemaker

PULMONARY:

- Coughing Shortness of breath Chest pains Wheezing

BREAST:

- Lumps Nipple Discharge Pain Tenderness

GI:

- Constipation Heartburn Blood in stool Diarrhea Nausea
 Vomiting Problems swallowing Pain with swallowing

GU:

- Difficulty urinating Painful urination Incontinence
 Blood in urine

MUSCULOSKELETAL:

- Arthritis Ankle swelling Pain with walking Joint Pain

SKIN:

- Rash Easy bruising Jaundice Black or changing moles

NEURO:

- Dizziness Loss of balance Headache

OTHER:

- Prior radiation exposure

SOCIAL HISTORY:

Tobacco (amount): _____

Alcohol (amount): _____

FEMALES:

BREAST:

- History of breastfeeding Age you began menstruating: _____
 If menopausal, age of last menstruation: _____
 Age of first delivery: _____

Pregnancies: _____ Births: _____ Abortions/Miscarriages: _____

Marital Status: Single Married Divorced Widowed

Occupation: _____

Reviewed by: _____