LEXINGTON SURGERY
A Lexington Medical Center Physician Practice

Lexington Medical Park 2
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LexingtonSurgery.com

Lexington Medical Center

Medical History

Patient's Full Name: _____ Age: _____ Date: _____

Referring Doctor: _____ Regular Doctor: _____

Reason for Visit: _____

Past Medical History: Do you have or have you ever been treated for (check all that apply):

CARDIAC
- ☐ Heart Attack
- ☐ Coronary artery disease
- ☐ High Blood Pressure
- ☐ Heart Failure
- ☐ Irregular heart beat
- ☐ High cholesterol
- ☐ Pacemaker

PULMONARY
- ☐ Emphysema
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Sleep Apnea

GASTROINTESTINAL
- ☐ Hepatitis
- ☐ Chronic heart burn
- ☐ Ulcers
- ☐ Diverticulosis
- ☐ Polyps
- ☐ Hiatal Hernia

GENITOURINARY
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Kidney infections
- ☐ Chronic urinary infection

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid problems

NEUROLOGICAL
- ☐ Stroke
- ☐ Seizures

HEMATOLOGICAL
- ☐ Anemia
- ☐ Blood clots
- ☐ HIV

MUSCULOSKELETAL
- ☐ Arthritis – Joints
- ☐ Arthritis – Back
- ☐ Disc problems – Back
- ☐ Osteoporosis
- ☐ Gout
- ☐ Varicose Veins

PSYCHOLOGICAL
- ☐ Depression

EYES
- ☐ Glaucoma
- ☐ Blindness
- ☐ Cataracts

OTHER
- ☐ Lupus
- ☐ MRSA
- ☐ _____

CANCER
- ☐ Type _____
- ☐ Date _____

Past Surgical History: Please include date.

- ☐ Appendix _____
- ☐ Back (Disc) _____
- ☐ C-Section _____
- ☐ Heart Bypass _____
- ☐ Hernia _____
- ☐ Hysterectomy (Uterus) _____
- ☐ Gallbladder _____
- ☐ Tonsils _____
- ☐ Other _____
- _____

Medical Allergies: Please include reaction.

_____
_____
_____
_____
_____

Family Medical History: Please list medical problems, not names.

Father _____ Mother _____

Grandfather _____ Grandmother _____

Brother _____ Sister _____

_____ _____

_____ _____

CONTINUED ON NEXT PAGE

Social History:

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Current Employment: _____

_____

Retired: ☐ Yes ☐ No

Tobacco/Nicotine Use: ☐ None ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Vaping

PPD:_____ No. Years:_____ Quit Date:_____

Alcohol Use:

☐ Yes ☐ No Amount:_____

Will you accept blood products? ☐ Yes ☐ No

Physical Activity: ☐ Regularly ☐ Occasionally ☐ Rarely

Type of activity:_____

Review of Symptoms: Do you have or have you ever been treated for (check all that apply)?

HEENT
- ☐ Frequent headache
- ☐ Change in vision
- ☐ Dizziness
- ☐ Change in hearing
- ☐ Ringing in ears

CARDIAC
- ☐ Chest pain
- ☐ Racing pulse
- ☐ Leg swelling
- ☐ Lightheadedness

PULMONARY
- ☐ Shortness of Breath
  - ☐ at rest ☐ with exertion
- ☐ Cough
- ☐ Wheezing

GASTROINTESTINAL
- ☐ Nausea / Vomiting
- ☐ Difficulty swallowing
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool

GENITOURINARY
- ☐ Blood in urine
- ☐ Painful urination
- ☐ Night time urination
- ☐ Incontinence

MUSCULOSKELETAL
- ☐ Muscle weakness
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Back pain

GENERAL
- ☐ Fever / chills
- ☐ Weight loss / gain
- ☐ Night sweats
- ☐ Hotter than usual
- ☐ Colder than usual
- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Daytime sleepiness
- ☐ Snoring
- ☐ Waking up at night
- ☐ Rash

BREAST
- ☐ Lumps
- ☐ Nipple Discharge
- ☐ Pain
- ☐ Tenderness

FOR OFFICE USE ONLY

Physical Exam

Height_____ Weight_____ BMI_____ BP_____ HR_____

General: ☐ WNL _____ Neck: ☐ WNL _____ Lungs: ☐ WNL _____ Ext: ☐ WNL _____

HEENT: ☐ WNL _____ Heart: ☐ WNL _____ Abd: ☐ WNL _____