Lexington Internists
NORTHEAST
A Lexington Medical Center Physician Practice

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Lexington Medical Center

New Patient History

Patient Name:_____ **Date of Birth:**_____

Referring Physician Name:_____

I have a: ☐ Living will ☐ Durable Medical Power of Attorney for Healthcare

Emergency Contact Name:_____

Relationship to Patient:_____ Phone:_____

Previous Surgeries/Hospitalizations:

Date	Location	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Chronic Medical Conditions:

Arthritis: ☐ Y ☐ N
Renal/Kidney Disease: ☐ Y ☐ N
Cancer: ☐ Y ☐ N Type:_____
Gastrointestinal: ☐ Y ☐ N
High Blood Pressure: ☐ Y ☐ N
Others:_____
Cardiac/Heart: ☐ Y ☐ N
Diabetes: ☐ Y ☐ N

Have you ever received blood transfusions or blood products? ☐ Yes ☐ No When:_____

Family History

Mother: ☐ Diabetes ☐ Cancer: Breast/Colon/Ovary ☐ Heart Disease ☐ High Cholesterol ☐ Deceased

Father: ☐ Diabetes ☐ Cancer: Colon/Prostate ☐ Heart Disease ☐ High Cholesterol ☐ Deceased

Siblings: ☐ Diabetes ☐ Cancer:_____ ☐ Heart Disease ☐ High Cholesterol ☐ Deceased

Other:_____

Allergies: ☐ None ☐ Food ☐ Drugs ☐ Latex ☐ Other:_____

Medications

All prescription medications & doses and over the counter medications/herbs/supplements routinely taken:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

CONTINUED ON BACK

Spiritual Screen

Do you have any spiritual, cultural or ethic beliefs/practices that we should be aware of? ☐ Yes ☐ No

If yes, please describe:_____

Lifestyle and Health Management Screen

Tobacco: ☐ Yes ☐ No Amount:_____ Date started:_____ Date quit:_____

Alcohol: ☐ Yes ☐ No Amount:_____ Date started:_____ Date quit:_____

Recreational Drugs: ☐ Yes ☐ No Amount:_____ Date started:_____ Date quit:_____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widow/Widower

Occupation:_____ Retired? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No Type:_____ How Often:_____

Have you received a Tetanus vaccine within the last 10 years? ☐ Yes ☐ No If yes, date received:_____

Have you received a Pneumonia vaccine? (age 65 or older) ☐ Yes ☐ No If yes, date received:_____

Have you received a Flu vaccine this year between October-March? ☐ Yes ☐ No If yes, date received:_____

Have you received a shingles vaccine? ☐ Yes ☐ No If yes, date received:_____

Date of last colonoscopy:_____

Women Only:

Date of last period:_____ **Last pap smear:**_____ **Last breast exam:**_____ **Last mammogram:**_____

Cycles (please check one): ☐ Regular ☐ Irregular

How many pregnancies:_____ **How many children:**_____

Do you have a gynecologist? ☐ Yes ☐ No Doctor's name:_____

Abuse Screen

Are you in a relationship where you are being hurt, kicked, slapped, or made to feel afraid? ☐ Yes ☐ No

Any additional information pertinent to your medical history not previously listed:_____

_____

_____

_____

_____

_____

_____