Riverside
SURGICAL GROUP
A Lexington Medical Center Physician Practice

Lexington Medical Park 2
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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

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

GASTROINTESTINAL
- ❑ Hepatitis
- ❑ Chronic heart burn
- ❑ Ulcers
- ❑ Diverticulosis
- ❑ Polyps

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

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.

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

Father ________________________ Mother ________________________

Grandfather ________________________ Grandmother ________________________

Brother ________________________ Sister ________________________

________________________ ________________________

________________________ ________________________

Continued ~

Social History:

MARITAL STATUS: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Current Employment: ____________________________________

____

Retired: ❑ Yes ❑ No

Tobacco Use: ❑ None ❑ Cigarettes ❑ Cigars ❑ Pipes

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

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 __________