The Columbia Medical Group
A Lexington Medical Center Physician Practice

Lexington Medical Center

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Health History

Patient Name:	**Date of Birth:**
Today's Date:	**When was your last annual physician exam:**

To help us meet all of your health care needs, please fill out this form completely. This is a confidential record of your medical history and will be kept in this office.

1. PAST MEDICAL HISTORY – Have you ever had the following: ☐ **I deny any past medical illness(es)**

	DATE		DATE		DATE
☐ Heart Disease		☐ Headaches		☐ Thyroid Disease	
☐ Diabetes		☐ Asthma		☐ Stomach Ulcers	
☐ Hepatitis		☐ Depression		☐ Blood in Urine	
☐ Blood Transfusions		☐ Seizures		☐ Kidney Problems	
☐ Stroke		☐ Kidney Stones		☐ Radiation Therapy	
☐ HIV / AIDS		☐ Bladder Infections		☐ High Cholesterol	
☐ Hypertension		☐ Cancer:_____		☐ Other Medical Disease:_____	

2. PAST SURGICAL HISTORY – Have you ever had the following: ☐ **I deny any past surgeries**

Please list all serious illnesses, operations, & other hospitalizations you have experienced and indicate the year these occurred.

	DATE		DATE		DATE
☐ Appendectomy		☐ Cardiac Bypass		☐ Hemorrhoids	
☐ Arthroscopy		☐ Cardiac Valve		☐ Hernia	
☐ Back Surgery		☐ Cataract		☐ Joint Replacement	
☐ Cardiac Cath		☐ Gall Bladder		☐ Hysterectomy	
☐ Angioplasty / Stent		☐ Colon / Intestinal Surgery		☐ Mastectomy	
☐ Breast Surgery		☐ Spleen Removal		☐ Tonsillectomy	
☐ Prostate Surgery		☐ Lithotripsy		☐ C-Section	
☐ Laser Retina Therapy		☐ Tubal Ligation			
☐ Other Surgery:					

3. MEDICATIONS – Please list all the medications you are taking. ☐ **I am NOT currently taking any medications**

CURRENT MEDICATIONS	DOSAGE (mg)	How often per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		

4. PLEASE LIST ALL ALLERGIES (food / drug / environmental) and reaction ☐ **I deny any know ALLERGIES**

MEDICATION / FOOD / ENVIRONMENTAL ALLERGEN	REACTION	
1.		
2.		
3.		
4.		

5. MENSTRUAL / GYNECOLOGICAL HISTORY

1. Age of first Menstrual Period:	2. Do you still have Menstrual periods? ☐ Yes ☐ No
3. Date of last Menstrual Period:	4. Number of Pregnancies:
5. Number of miscarriages / abortions:	6. Number of live births:
7. Number of living children:	8. Do you have any twins? ☐ Yes ☐ No If yes, How many:

Children's Dates of Birth: SON Date:_____ SON Date:_____ SON Date:_____ SON Date:_____

DAUGHTER Date:_____ DAUGHTER Date:_____ DAUGHTER Date:_____ DAUGHTER Date:_____

6. FAMILY HISTORY

Relationship	Alive (age)	Deceased (age)	Illness / Cause of Death	Diabetes	Hypertension	Heart Attack	Stroke	Cancer	Seizures/Epilepsy	Bleeding Disorder	Kidney Disease	Thyroid Disease	Mental Illness
Father													
Mother													
Maternal Grandmother													
Maternal Grandfather													
Paternal Grandmother													
Paternal Grandfather													
1 Brother / Sister													
2 Brother / Sister													
3 Brother / Sister													
4 Brother / Sister													

7. DIAGNOSTIC AND SCREENING TESTS

TEST	PHYSICIAN	WHY	WHEN
☐ Colonoscopy			
☐ Upper Endoscopy			
☐ Mammogram			
☐ PAP Smear			
☐ Bone Density Study			
☐ Cardiac Catheterization			
☐ Stress Test			
☐ CT Scan			
☐ MRI:			

8. SOCIAL HISTORY

Place of Birth:	**Childhood Home:**	
Education	High School:	☐ Finished ☐ Did not complete
	College:	☐ Finished ☐ Did not complete
	Graduate:	Degree:

Military Service: ☐ Yes ☐ No ☐ Branch of Service:_____ ☐ Dates of Service:_____

☐ Service Connected Injury:_____ ☐ Location of Station / Travel:_____

Tobacco: (type and amount):	**Former Smoker:** Date quit:
Alcohol: (type and amount):	**Caffeine:** (type and amount):

Street Drugs: (type and amount):	☐ Marijuana:	☐ Cocaine:	☐ Crack:	☐ LSD:
	☐ Ecstasy:	☐ Amphetamine:	☐ Barbiturates:	☐ Steroids:

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widow(er)

Exercise: ☐ None ☐ Irregular ☐ Regular

Health Care Legal Matters: indicate which of the following you currently have	☐ Health Care power of Attorney Attorney:
	☐ Living Will

Have you traveled outside the United States: ☐ Yes ☐ No If yes, please list where and when.

Work History: Employer: Job Description:

History of Exposure: indicate any possible toxin exposures	☐ Asbestos ☐ Pesticides ☐ Organophosphates ☐ Loud Noises ☐ Ionizing Radiation ☐ Inhaled Toxins ☐ Sandblasting / Silica ☐ Dusts ☐ Other:_____

IMMUNIZATIONS	DATE	IMMUNIZATIONS	DATE
Tetanus		Hepatitis A	
Diphtheria		Hepatitis B	
Pneumonia		Polio	
Influenza		Smallpox	
Meningitis		Other:	
Other:		Other:	

9. SYMPTOM AND SYSTEM REVIEW

Do you have NOW – or during the past twelve months – have you had any of the following:

GENERAL / CONSTITUTIONAL	☐ Fever	☐ Chills	☐ Fatigue	☐ Night Sweats
	☐ Weight Loss	☐ Weight Gain	☐ Snoring	☐ Non-Restorative Sleep
EYES	☐ Change in Vision	☐ Loss of Vision	☐ Blurred / Double Vision	☐ Flashing Lights
HEENT	☐ Headaches	☐ Change in Hearing	☐ Loss of Hearing	☐ Ear Pain
	☐ Nose Bleeds	☐ Nasal Congestion	☐ Recurrent Sinus Probs.	☐ Recurrent Sore Throats
	☐ Bleeding Gums	☐ Mouth Sores / Lesions	☐ Recurrent Hoarseness	
BREASTS	☐ Lumps	☐ Tenderness	☐ Discharge	
RESPIRATORY	☐ Recurrent Cough	☐ Sputum / Phlegm	☐ Blood in Sputum	☐ Shortness of Breath
	☐ Wheezing	☐ Pain with Breathing	☐ Asthma	☐ Sleep Apnea
CARDIOVASCULAR	☐ Palpitations	☐ Shortness of Breath:	☐ Leg Cramps:	☐ Chest Pain:
	☐ Irregular Heartbeat	☐ Lying Down	☐ At night	☐ At Rest
	☐ Fainting	☐ Exertional	☐ Exertional	☐ Exertional
	☐ Stroke / TIA	☐ Ankle Swelling		☐ With Stress
GASTROINTESTINAL	☐ Nausea	☐ Vomiting	☐ Heartburn	☐ Diarrhea
	☐ Constipation	☐ Abdominal Pain	☐ Bloating	☐ Loss of Appetite
	☐ Blood in Stools	☐ Rectal Pain	☐ Jaundice	☐ Irritable Bowel Sxs
	☐ Recurrent Hiccoughs			
GENITOURINARY	☐ Frequent Urination	☐ Nighttime Urination	☐ Burning with Urination	☐ Blood in Urine
	☐ Incontinence	☐ Difficulty Voiding	☐ Decreased Stream	☐ Erectile Problems
	☐ Pain with Intercourse	☐ Post Void Dribbling	☐ Urinary Infections	☐ Flank Pain
	☐ Testicular Pain	☐ Testicular Nodule / Mass	☐ STD	
SKIN / INTEGUMENT	☐ Rash	☐ Itching	☐ Change in Mole	☐ New Skin Lesion
NEUROLOGICAL	☐ Tingling / Numbness	☐ Gait / Walking Problem	☐ Tremor	☐ Seizure
	☐ Difficulty with Speech	☐ Memory Problems	☐ Confusion	
MUSCULOSKELETAL	☐ Joint Pain	☐ Joint Stiffness	☐ Joint Swelling / Redness	☐ Morning Stiffness
	☐ Limited Motion	☐ Back Pain	☐ Muscle Pain	☐ Loss of Muscle Mass
	☐ Muscle Weakness	☐ Gout	☐ Sciatica	
ENDOCRIN	☐ Excessive Thirst	☐ Change / Loss of Hair	☐ Change in Nails	☐ Heat Intolerance
	☐ Cold Intolerance	☐ Hot Flashes		
HEME / LYMPH	☐ Easy Bruising	☐ Easy Bleeding	☐ Lymph Node(s)	
PSYCHIATRIC	☐ Anxiety	☐ Depression	☐ Suicidal Thoughts	
ALLERGY / IMMUNOLOGIC	☐ Sinus Allergies	☐ Recurrent Sneezing	☐ Allergic Dermatitis	

_____ _____

Patient Signature (or Parent or Guardian of Minor) Date