Lexington
Medical Specialists
A Lexington Medical Center Physician Practice

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Lexington Medical Center

# New Patient Questionnaire

Patient Name:_____

Date: _____

## REVIEW OF SYMPTOMS

**Are you CURRENTLY having any of the symptoms listed below?**

**1. Constitutional:**
- Fever: ☐ Yes ☐ No
- Chills: ☐ Yes ☐ No
- Sweats: ☐ Yes ☐ No
- Weight Loss: ☐ Yes ☐ No

**2. Eye/Ear/Nose/Throat:**
- Vision Changes: ☐ Yes ☐ No
- Sore Throat: ☐ Yes ☐ No
- Pain/Difficulty: ☐ Yes ☐ No
- Swallowing: ☐ Yes ☐ No
- Nose Congestion: ☐ Yes ☐ No

**3. Infections:**
- HIV: ☐ Yes ☐ No
- Hepatitis: ☐ Yes ☐ No
- Boils/Furuncles: ☐ Yes ☐ No

**4. Cardiovascular:**
- Chest Pain: ☐ Yes ☐ No

**5. Respiratory:**
- Shortness of Breath: ☐ Yes ☐ No
- Difficulty Breathing: ☐ Yes ☐ No
- Expectoration: ☐ Yes ☐ No

**6. Gastrointestinal:**
- Diarrhea: ☐ Yes ☐ No
- Stomach Pain: ☐ Yes ☐ No
- Vomiting: ☐ Yes ☐ No
- Blood in Stools: ☐ Yes ☐ No
- Nausea: ☐ Yes ☐ No

**7. Urinary:**
- Blood in Urine: ☐ Yes ☐ No
- Pain with Urination: ☐ Yes ☐ No

**8. Endocrine:**
- Thyroid Problems: ☐ Yes ☐ No
- Diabetes: ☐ Yes ☐ No

**9. Neurological:**
- Headache: ☐ Yes ☐ No
- Migraine: ☐ Yes ☐ No
- Seizures: ☐ Yes ☐ No
- Numbness: ☐ Yes ☐ No
- Weakness: ☐ Yes ☐ No

**10. Musculoskeletal:**
- Muscle Aches: ☐ Yes ☐ No
- Joint Swelling: ☐ Yes ☐ No
- Joint Pain: ☐ Yes ☐ No
- Back Pain: ☐ Yes ☐ No

**11. Integumentary:**
- Skin Rashes and/or Outbreaks: ☐ Yes ☐ No

**12. Tobacco Use:** ☐ Yes ☐ No

**13. Former Tobacco Use:** ☐ Yes ☐ No

**14. Alcohol Use:** ☐ Yes ☐ No

**15. Drug Use:** ☐ Yes ☐ No

**16. Travel Outside Country:** ☐ Yes ☐ No

Where:_____

When:_____

**17. Live With:**

_____

**18. Occupation:**

_____

**19. # of Pets:**_____

**20. Flu Shot this Season:** ☐ Yes ☐ No

OFFICE USE ONLY

**Physician Signature:**_____ **Date:**_____

Patient Name: _____ DOB: _____

Referring Physician: _____ Date of visit: _____

Medication Allergies: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

What is the reason you are here today? _____

_____

How has this problem been treated so far? _____

_____

Have you had any testing done yet? ☐ CT Scan ☐ MRI ☐ Bone Scan ☐ Cultures

## PAST MEDICAL/SURGICAL HISTORY (Have you ever had the following?):

### MEDICAL HISTORY

| | | | |
|---|---|---|---|
| ☐ None | | | |
| ☐ Heart Disease | Date: _____ | ☐ Lung Problems | Date: _____ |
| ☐ Diabetes | Date: _____ | ☐ Depression | Date: _____ |
| ☐ Hepatitis | Date: _____ | ☐ Kidney Stones | Date: _____ |
| ☐ Stroke | Date: _____ | ☐ GERD/Reflux | Date: _____ |
| ☐ HIV/AIDS | Date: _____ | ☐ Thyroid Disease | Date: _____ |
| ☐ Cancer | Date: _____ | ☐ Blood Clots/DVT | Date: _____ |

### SURGICAL HISTORY

| | | | |
|---|---|---|---|
| ☐ None | | | |
| ☐ Heart Valve | Date: _____ | ☐ Joint Replacement | Date: _____ |
| ☐ Cardiac Cath. | Date: _____ | ☐ Pacemaker/Defibrillator | Date: _____ |
| ☐ Angioplasty/Stent | Date: _____ | ☐ Bone or Spine Surgery | Date: _____ |
| ☐ Cardiac Surgery | Date: _____ | ☐ Other Surgeries | Date: _____ |

Other Illnesses: _____

_____

Other Surgeries: _____

_____

Family History: ☐ Auto Immune ☐ Lupus ☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Cancer ☐ Other: _____

**PATIENT SIGNATURE:** _____ **DATE:** _____