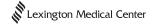


A Lexington Medical Center Physician Practice

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LexingtonRheumatology.com

New Patient History Form ___ DOB ______ DATE _____ PATIENT NAME PRIMARY CARE PHYSICIAN CHART #____ Briefly tell us the reason for your visit today:_ PAST MEDICAL HISTORY List your current medical problems (with year of diagnosis) and any hospitalizations. **CURRENT MEDICAL PROBLEMS:** YEAR **CURRENT MEDICAL PROBLEMS:** YEAR 1. 2. 3. ANY PREVIOUS FRACTURES? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE: ANY OTHER SERIOUS INJURIES? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE: HAVE YOU BEEN TESTED FOR: Hepatitis B: ☐ Yes ☐ No If Yes, Result/Year:_ Hepatitis C: ☐ Yes ☐ No If Yes, Result/Year:_ HIV: ☐ Yes ☐ No If Yes, Result/Year: LIST SURGERIES YOU WOULD CONSIDER SIGNIFICANT: YEAR LIST SURGERIES YOU WOULD CONSIDER SIGNIFICANT: YEAR 2. 3. 4. **Social History** Do you smoke? ☐ Yes ☐ No Number of packs per day?___ How many years?_ Do you currently drink alcohol? \square Yes \square No How often? Previous regular use? ☐ Yes ☐ No Do you use any substances such as cocaine or marijuana? ☐ Yes ☐ No If yes, please list:_ _How often?_ Are you employed? ☐ Yes ☐ No If yes, occupation?_ On Disability? ☐ Yes ☐ No If yes, reason? Family History Please check and indicate which family member in the space provided. \square Gout ☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis ☐ Diabetes ☐ Osteoarthritis ☐ Psoriasis ☐ High Blood Pressure ☐ Lupus ☐ Crohn's/Ulcerative Colitis ☐ Tuberculosis ☐ Fibromyalgia ☐ Osteoporosis

Review of Systems Please check Y (Yes) or N (No) and fill in the blanks where appropriate.									
CONSTITUTIONAL			RESPIRATORY			MUSCULOSKELETAL			
Weight Weight Feel W Heat/O	ing Fever i Loss III the Time leak all Over iold Intolerance	Y	N	Chest hurts with a deep breath Frequently feel short of breath Frequent Coughing Frequent Wheezing Snoring Recurrent Pneumonia Asthma	Y	N	Pain all over (muscles/joints) Joint Pains. Which ones? Muscle Pains. Location(s)? Body stiffness when you wake Joints swell. Which ones? Fingers or toes swell up like ho		
YN				CADDIOVACCIII AD		N			
Chang EY Y N Freque Freque	Thyroid Disease Change in Hat Size EYES Frequent Red Eyes Frequent Eye Pain		N	Chest pain with exertion Feel short of breath with mild exertion Recent Fainting Frequent Ankle Swelling			Pigment Changes Psoriasis Recurring Rashes. Where? Frequent Itching Brief sun exposure causes a sk Recent finger or toe nail change All color drains out of fingertips Significant hair loss	in rash es	
	Chronic Eye Dryness Recent Vision Changes	.,	GASTROINTESTINAL		HEMATOLOGIC				
Y N Chroni	NT c Dryness in Mouth ent Mouth Ulcers	Y	N	Heartburning Frequent Nausea Crohn's/Ulcerative Colitis IBS (Irritable Bowel) Blood in stool or black/tarry stool	Y	N 	Frequent Swollen Glands Treated for a blood clot. Body p Excessive Bleeding Frequent Nosebleeds Excessive Bruising	art?	
	Chronic Hoarseness Hearing Loss			URINARY		NEUROLOGIC			
Y N			Pain When Urinating Blood in Urine Kidney Stones Frequent Bladder Infections Frequent Genital Ulcers	Y N ☐ ☐ Headaches ☐ Seizures ☐ ☐ Numbness. Body Part(s): ☐ ☐ Burning Sensation. Body Part(s): ☐ ☐ Pins-and-needle sensation. Body Part(s): ☐ ☐ Recent weakness of a body part:					
Number of times r	oregnant:					PSYCHIATRIC			
Number of live births:					Y	□ Depression□ Anxiety□ Confusion□ Sleep Disorder:			
CURRENT MEDICATIONS Please list all medications including prescription, over-the-counter and vitamins									
DRUG ALLERGIES YES NO TO WHAT? TYPE OF REACTION?									
NAME OF MEDICATION							DOSAGE	FREQUENCY	
					\dashv				
HERBAL OR NATURAL SUPPLEMENT							DOSAGE	FREQUENCY	
					\dashv				
PATIENT SIGNATURE	PATIENT SIGNATURE DATE								
PHYSICIAN SIGNATURE DATE									