Lexington Rheumatology
A Lexington Medical Center Physician Practice

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Lexington Medical Center

New Patient History Form

PATIENT NAME _____ DOB _____ DATE _____

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.			
4.			

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
1.			
2.			
3.			
4.			

Social History

Do you smoke? ☐ Yes ☐ No	Number of packs per day?_____	How many years?_____
Do you currently drink alcohol? ☐ Yes ☐ 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.

☐ Rheumatoid Arthritis	☐ Gout	☐ Ankylosing Spondylitis	☐ Diabetes
☐ Lupus	☐ Osteoarthritis	☐ Psoriasis	☐ High Blood Pressure
☐ Fibromyalgia	☐ Osteoporosis	☐ Crohn's/Ulcerative Colitis	☐ Tuberculosis

Please complete the back portion of this form.

Review of Systems Please check Y (Yes) or N (No) and fill in the blanks where appropriate.

CONSTITUTIONAL

Y	N	
☐	☐	Recurring Fever
☐	☐	Weight Loss
☐	☐	Tired all the Time
☐	☐	Feel Weak all Over
☐	☐	Heat/Cold Intolerance

ENDOCRINE

Y	N	
☐	☐	Thyroid Disease
☐	☐	Change in Hat Size

EYES

Y	N	
☐	☐	Frequent Red Eyes
☐	☐	Frequent Eye Pain
☐	☐	Chronic Eye Dryness
☐	☐	Recent Vision Changes

ENT

Y	N	
☐	☐	Chronic Dryness in Mouth
☐	☐	Frequent Mouth Ulcers
☐	☐	Chronic Hoarseness
☐	☐	Hearing Loss

RESPIRATORY

Y	N	
☐	☐	Chest hurts with a deep breath
☐	☐	Frequently feel short of breath
☐	☐	Frequent Coughing
☐	☐	Frequent Wheezing
☐	☐	Snoring
☐	☐	Recurrent Pneumonia
☐	☐	Asthma

CARDIOVASCULAR

Y	N	
☐	☐	Chest pain with exertion
☐	☐	Feel short of breath with mild exertion
☐	☐	Recent Fainting
☐	☐	Frequent Ankle Swelling

GASTROINTESTINAL

Y	N	
☐	☐	Heartburning
☐	☐	Frequent Nausea
☐	☐	Crohn's/Ulcerative Colitis
☐	☐	IBS (Irritable Bowel)
☐	☐	Blood in stool or black/tarry stool

URINARY

Y	N	
☐	☐	Pain When Urinating
☐	☐	Blood in Urine
☐	☐	Kidney Stones
☐	☐	Frequent Bladder Infections
☐	☐	Frequent Genital Ulcers

Number of times pregnant: _____

Number of live births: _____

Number of miscarriages: _____

Number of abortions: _____

Method of contraception: _____

MUSCULOSKELETAL

Y	N	
☐	☐	Pain all over (muscles/joints)
☐	☐	Joint Pains. Which ones? _____
☐	☐	Muscle Pains. Location(s)? _____
☐	☐	Body stiffness when you wake up. Lasts how long? _____
☐	☐	Joints swell. Which ones? _____
☐	☐	Fingers or toes swell up like hot dogs

SKIN

Y	N	
☐	☐	Pigment Changes
☐	☐	Psoriasis
☐	☐	Recurring Rashes. Where? _____
☐	☐	Frequent Itching
☐	☐	Brief sun exposure causes a skin rash
☐	☐	Recent finger or toe nail changes
☐	☐	All color drains out of fingertips when it's cold
☐	☐	Significant hair loss

HEMATOLOGIC

Y	N	
☐	☐	Frequent Swollen Glands
☐	☐	Treated for a blood clot. Body part? _____
☐	☐	Excessive Bleeding
☐	☐	Frequent Nosebleeds
☐	☐	Excessive Bruising

NEUROLOGIC

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: _____

PSYCHIATRIC

Y	N	
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Confusion
☐	☐	Sleep Disorder: _____
☐	☐	Sleep Problems: ☐ Falling Asleep ☐ Staying Asleep

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

HERBAL OR NATURAL SUPPLEMENT	DOSAGE	FREQUENCY

PATIENT SIGNATURE _____ DATE _____

PHYSICIAN SIGNATURE _____ DATE _____

Thank you for allowing us to assist you with your health care needs. We look forward to serving you.