Lexington
Medical Specialists
A Lexington Medical Center Physician Practice

Lexington Medical Park 2, 146 East Hospital Drive, Suite 120A, West Columbia, SC 29169
Ph: (803) 936-7460 • Fx: (803) 936-7462

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
- Appetite Change: ☐ Yes ☐ No

2. Eye/Ear/Nose/Throat:
- Vision Changes: ☐ Yes ☐ No
- Sore Throat: ☐ Yes ☐ No
- Swallowing Problem: ☐ 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
- Cough: ☐ Yes ☐ No
- Coughing up Blood: ☐ Yes ☐ No

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

7. Genitourinary:
- Blood in Urine: ☐ Yes ☐ No
- Pain with Urination: ☐ Yes ☐ No
- Genital or Penile Sores: ☐ Yes ☐ No
- Vaginal Discharge: ☐ Yes ☐ No

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

9. Neurological:
- Lightheadedness/Dizziness: ☐ Yes ☐ No
- 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:** _____