HARBISON
MEDICAL ASSOCIATES
A Lexington Medical Center Physician Practice

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Lexington Medical Center

Medical History

Date:_____

Patient Name: _____ Age: _____ Birthdate: _____/_____/_____ Sex: ☐ M ☐ F

Address: _____

_____

Home phone: _____ Work phone: _____

Occupation: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated If married, spouse's name: _____

Children's names and ages: _____

_____

Emergency contact: _____ Phone:_____

Allergies to Medications, X-Ray Dyes or Other Substances ■ Yes ■ No

If yes, please list name of medicine and type of reaction.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Past Medical History & Review of Systems

Please check if **YOU** have had problems with or are presently complaining of any of the following.

☐ High blood pressure	☐ Rheumatic fever	☐ Vomitting	☐ Hepatitis or jaundice	☐ Blood disorders
☐ Diabetes	☐ Asthma	☐ Constipation	☐ Thyroid disease	☐ Venereal diseases
☐ Cancer	☐ Bronchitis	☐ Diarrhea	☐ Head or neck radiation	☐ Anxiety
☐ Heart disease	☐ Pneumonia	☐ Blood in stool	☐ Headache	☐ Depression
☐ Chest pain/chest tightness	☐ Persistent cough	☐ Ulcers	☐ Kidney disease	☐ Anemia
☐ Shortness of breath	☐ T.B.	☐ Change in bowel habits	☐ Kidney stones	☐ Alcohol abuse
☐ Swollen ankles	☐ Hay fever	☐ Unexplained weight gain/loss	☐ Difficulty urinating	☐ Drug abuse
☐ Palpitations	☐ Abdominal discomfort	☐ Hemorrhoids	☐ Arthritis	☐ Gout
☐ Lightheadedness	☐ Indigestion	☐ Gall bladder disease	☐ Low back problems	☐ _____
☐ Frequent urination	☐ Nausea	☐ Colitis	☐ Skin diseases	☐ _____

_____

_____

_____

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_____

_____

_____

Gynecologic & Obstetric History

Age at onset of periods: _____ Frequency: _____ Length of period: _____

Pregnancies: _____ Births: _____ Miscarriages:_____

Prolonged or abnormal bleeding: ☐ Yes ☐ No (Please describe): _____

Leakage of urine: ☐ Yes ☐ No (Please describe): _____

Pelvic Pain: ☐ Yes ☐ No (Please describe): _____

Abnormal discharge: ☐ Yes ☐ No (Please describe): _____

History of abnormal Pap smear: ☐ Yes ☐ No (Please describe): _____

Please list and supply the dates of:

Operations: _____ _____ _____
_____ _____ _____

Hospitalizations other than for surgery: _____ _____ _____
_____ _____ _____

IMMUNIZATION HISTORY – Have you had:

Hepatitis B? ☐ Yes ☐ No When? _____
Pneumovax immunization? ☐ Yes ☐ No When? _____
Flu immunization? ☐ Yes ☐ No When? _____
Tetanus immunization? ☐ Yes ☐ No When? _____
TB Test? ☐ Yes ☐ No When? _____
Other? _____ ☐ Yes ☐ No When? _____

When was your last:

Pap smear? _____ Breast exam? _____ Stool check for blood? _____
Mammogram? _____ Cholesterol check? _____ Prostate exam? _____

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Approx. age when diagnosed
☐ Cancer (type: _____)		
☐ Hypertension (high blood pressure)		
☐ Heart disease		
☐ Diabetes		
☐ Strokes		
☐ Mental disease (anxiety, depression, etc.)		
☐ Drug or alcohol addiction		
☐ Glaucoma		
☐ Bleeding disease		
☐ Other: _____		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose

Prevention

1. Do you wear seatbelts? ☐ Yes ☐ No If no, why not? _____
2. Do you wear a bike helmet? ☐ Yes ☐ No ☐ N/A
3. Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____
4. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how much per week? _____
5. Do you drink coffee? ☐ Yes ☐ No If yes, how many cups per day? _____
6. Do you drink tea? ☐ Yes ☐ No If yes, how many cups per day? _____
7. Is there a gun in your home, is it out of children's reach and unloaded? ☐ Yes ☐ No ☐ N/A
8. Do you use drugs? (marijuana, cocaine, crack, etc.) ☐ Yes ☐ No If yes, explain: _____
9. Have you ever engaged in any activity which has put you at risk of getting AIDS? ☐ Yes ☐ No If yes, explain: _____
10. Do you wish to be tested for AIDS? ☐ Yes ☐ No
11. Have you ever worked with chemicals, paints, asbestos, or other hazardous material? ☐ Yes ☐ No If yes, explain: _____
12. Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? ☐ Yes ☐ No
13. Do you ever feel afraid of your partner? ☐ Yes ☐ No
14. Do you have a "living will"? ☐ Yes ☐ No
15. Do you have a donor card? ☐ Yes ☐ No

Method of birth control? _____

Patient Signature: _____ Date: _____