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): ______________________________

8366-014-1 (3/21)

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: ____________