120 Shoal Creek Circle, Lexington SC 29072|P (866)757-7333 | F (800)720-5171| Mon-Fri 8-5PM After HRS Avail

Today's Date: _____

PATIENT INFORMATION FORM

Please provide the following information and answer the questions below. Please note: the information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Home/Cell phone: (____) _____ May we leave a message? ___Yes ___ No

E-mail: _____May we email you? Yes__ No__

***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Address:_____

_____
City State Zip

Employer: _____Occupation: _____

SSN: _____-____-_____ DOB: ___/____/___ Age____ Sex: ___Male ___Female ___Other

Race/Ethnicity: _____

Marital Status: ___Never Married __Married __Domestic Partnership __Divorced ___Widowed

Referred by (if any): _____

Emergency Contact Information:

Name: _____

Relation: _____

Emergency Phone: _____

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Patient Medical & social History

Have you ever had or suffered from any of the following?

Allergies Yes___ No___ Coughing up blood Yes___ No___

Asthma Yes___ No ___ Low Blood Sugar Yes___ No___

AIDS/HIV Yes___ No___ Epilepsy or Neurological Problems Yes___ No ___

High Blood Pressure Yes___ No___ Cancer Yes___ No___

Thyroid Problems Yes___ No___ Sinus Trouble Yes___ No___

Respiratory Problems Yes___ No___ Fainting Spells Yes___ No ___

Kidney Trouble Yes___ No___ Diabetes Yes___ No ___

Migraines Yes___ No___ Hepatitis/Jaundice/Liver Problems Yes___ No ___

Chronic cough Yes___ No___ Stomach Problems Yes___ No ___

Tuberculosis Yes___ No ___ Sexually Transmitted Diseases Yes___ No ___

Mental Health Problem Yes___ No ___ Immune System Problems Yes___ No ___

Congestive Heart Failure Yes___ No ___ High Cholesterol Yes___ No ___

Heart Disease Yes___ No ___ Thyroid Disease Yes___ No ___

Stroke Yes___ No ___ Arthritis Yes___ No ___ COPD Yes___ No ____

Do you have any allergies to?

Anesthesia Yes___ No___ Sulfa Drugs Yes ___ No___

Narcotics Yes___ No___ Penicillin or Antibiotics Yes___ No ____

Barbiturates Yes ___ No ___ Iodine Yes___ No ___ Other Yes___ No ___

If you have other allergies, please describe:_____

Hospitalizations: _____

Surgeries (Type and Date): _____

_____

Medications: _____

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Review of Symptoms:

*Please check if you have had any of the following in the **past week:***

Weight Loss or Gain Yes _____No ___

Night Sweats Yes ____ No ___

Muscle Weakness Yes ____ No ___

Skin Rashes Yes ____ No ___

Itching Yes ____ No ___

Dry Skin Yes ____ No ___

Headaches Yes ____ No ____

Injuries Yes ____ No ___

Blurred Vision Yes ____ No ___

Ringing in Ears Yes ____ No ___

Hearing Loss Yes ____ No ___

Muscle Pain Yes ____ No ___

Runny Nose Yes ____ No ___

Nose Bleed Yes ____ No ___

Joint Pain Yes ____ No ___

Cold Hands or Feet Yes ____ No ___

Feeling Cold Often Yes ____ No ___

Chest Pain Yes ___ No _____

Racing Heart Yes ___ No_____

Difficulty Breathing Yes ____ No ___

Coughing Yes ____ No ___

Seizures Yes ____ No ___

Dizziness Yes ____ No ___

Numbness Yes ____ No ___

Breast Pain Yes ____ No ___

Nipple Discharge Yes ____ No ___

Disorientation Yes ____ No ___

Loss/Increased Appetite Yes ____ No ___

Nausea Yes ____ No __

Vomiting Yes ____ No ___

Diarrhea Yes ____ No ___

Constipation Yes ____ No ___

Indigestion Yes ____ No ___

Excessive Sleeping Yes ____ No ___

*Please check if you have had any of the following in the **past week:** Continues…….*

Feeling Warm Often Yes ____ No ___

Sore Throat Yes ____ No ___

Hoarseness Yes ____ No ___

Fatigue Yes ____ No ___

Neck Stiffness Yes ____ No ___

Difficulty Sleeping Yes ____ No ___

Anxiety Yes ____ No ___

Mood Swings Yes ____ No ___

Depressed Mood Yes ____ No ___

Hair Loss/Growth Yes ____ No ___

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How would you rate your current sleeping habits?

___Poor ____Unsatisfactory _____Satisfactory _____Good _____Very Good Please

List any specific sleep problems you are currently experiencing: _____

_____

Do you follow a particular diet? ____Yes ____No If so, what type: _____

Do you use tobacco? _____Yes _____No If so, how often: _____

Do you use alcohol? _____ Yes _____No If so, how often: _____

Purpose of today's visit and list any specific health problems you are currently experiencing:

_____

_____

_____

Preferred Pharmacy: _____

Address: _____

Family Medical History

Please list all first- degree relatives who have experienced the following:
(parents, full siblings, or children)

Heart Attack_____

Stroke: _____

Diabetes: _____

High Blood Pressure: _____

Cancer: _____

Sudden Death: _____

Other: _____

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Women Only

Date of your last menstrual period_____(mm/dd/yyyy)

Do your periods come every month ___Yes ____No?
If no, how often? _____

How long do your periods last? _____
Is your flow: ____Light ____Medium ____Heavy

Do you have pain or bleeding after sexual intercourse? ____Yes ____No

Have you been pregnant? ___Yes ___No If yes, how many children do you have? ____

Are you currently taking birth control? ____Yes ____ No
If so, what kind? _____

Date of your last pap smear: _____(mm/dd/yyyy)
Have you ever had an abnormal pap? ___ Yes ___ No

When was your last mammogram/breast exam: _____mm/dd/yyyy
Was it normal? ____ Yes ____ No Do you do self-breast examinations? ____Yes ____No

Social History

Do you exercise regularly? ___ Yes ____ No
If so, how often and what type? _____
_____
_____