

Today's Date:			
PATIENT INFORMAT	TION FOR	M	
Please provide the following infor information you provide here is pi		•	note: the
Name:(Last)	(First)	(Mid	
Name of parent/guardian (if unde	, ,	(IVIII)	luic
(Last)	(First)	(Middle Ini	itial)
Home/Cell phone: ()		May we leave a message? _	Yes No
E-mail:		May we email yo	u? Yes No
communication. Address: City		State	7in
,			Zip
Employer:		_Occupation:	
SSN: DOB: _ Race/Ethnicity:			maleOther
Marital Status:Never Married	dMarried[Domestic PartnershipDivorced	dWidowed
Referred by (if any):			
Emergency Contact Information: Name:			
Relation:			

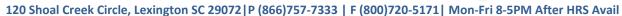
Emergency Phone:



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

Patient Medical & social History

Have you ever had or suffered from any of Allergies Yes No	of the following? 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 describ	oe:
Hospitalizations:	
Surgeries (Type and Date):	
Medications:	





Review of Symptoms: Please check if you have had any of the fo	ollowing in the past week:
Weight Loss or Gain YesNo	Chest Pain Yes No
Night Sweats Yes No	Racing Heart Yes No
Muscle Weakness Yes No	Difficulty Breathing Yes No
Skin Rashes Yes No	Coughing Yes No
Itching Yes No	Seizures Yes No
Dry Skin Yes No	Dizziness Yes No
Headaches Yes No	Numbness Yes No
Injuries Yes No	Breast Pain Yes No
Blurred Vision Yes No	Nipple Discharge Yes No
Ringing in Ears Yes No	Disorientation Yes No
Hearing Loss Yes No	Loss/Increased Appetite Yes No
Muscle Pain Yes No	Nausea Yes No
Runny Nose Yes No	Vomiting Yes No
Nose Bleed Yes No	Diarrhea Yes No
Joint Pain Yes No	Constipation Yes No
Cold Hands or Feet Yes No	Indigestion Yes No
Feeling Cold Often Yes No	Excessive Sleeping Yes No
Please check if you have had any of the for Feeling Warm Often Yes No	ollowing in the past week: Continues Difficulty Sleeping Yes No
Sore Throat Yes No	Anxiety Yes No
Hoarseness Yes No	Mood Swings Yes No
Fatigue Yes No	Depressed Mood Yes No
Neck Stiffness Yes No	Hair Loss/Growth Yes No



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How would	d you rate your currer	nt sleeping habits	?	
Poor	Unsatisfactory	Satisfactory	Good	Very Good Please
List any sp	ecific sleep problems	you are currently	experienci	ng:
Do you fol	low a particular diet?	YesNo	If so, what t	rype:
Do you use	e tobacco?Yes _	No If so, how	w often:	
Do you use	e alcohol? Yes _	No If so, how	w often:	
Purpose of	f today's visit and list	any specific healt	h problems	you are currently experiencing:
Preferred I	Pharmacy:			
Address: _				
		Family Medic	cal Histor	У
	all first- degree relativ ull siblings, or children	•	erienced th	e following:
Heart Atta	ick			
Stroke:				
High Blood	d Pressure:			
	eath:			



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Women Only

Date of your last menstrual period(mm/c	d/yyyy)
Do your periods come every monthYesNo? If no, how often?	
How long do your periods last? Is your flow:LightMediumHeavy	
Do you have pain or bleeding after sexual intercourse?YesNo	
Have you been pregnant?YesNo 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 Was it normal? Yes No Do you do self-breast examinations? Yes Yes No Yes	
Social History	
Do you exercise regularly? Yes No If so, how often and what type?	