Lexington Neurology
A Lexington Medical Center Physician Practice

Lexington Medical Park 2
146 East Hospital Drive, Suite 140, West Columbia, SC 29169
(803) 936-7076 • **Fax:** (803) 936-7925
LexNeurology.com

Patient History

Patient Name: _____ Date of Birth: _____

Referring Physician: _____ Phone: _____

Address: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Main problems and areas of concern	**Onset** (age or date)
1.	
2.	
3.	
4.	

PAST MEDICAL HISTORY (Please check the appropriate answer)

Diagnosis	Yes	No	Year	Diagnosis	Yes	No	Year
Anxiety Disorder	☐	☐		Hypertension (High Blood pressure)	☐	☐	
Asthma	☐	☐		Mood/Bipolar Disorder	☐	☐	
Balance Problem	☐	☐		Numbness/Pain	☐	☐	
Bipolar Disorder	☐	☐		Parkinsonism	☐	☐	
Cancer	☐	☐		PTSD (Post Traumatic Stress Disorder)	☐	☐	
Cholesterol Problems	☐	☐		Restless Leg	☐	☐	
CVA (Stroke)	☐	☐		Seizure Disorder	☐	☐	
Depression	☐	☐		Skin Problems	☐	☐	
Diabetes	☐	☐		Sleep Apnea	☐	☐	
Eating Disorder	☐	☐		Other Sleep Disorders	☐	☐	
Emphysema	☐	☐		Stomach/Bowel Problems	☐	☐	
Fibromyalgia	☐	☐		Tremors	☐	☐	
Head Injury	☐	☐		Weight Loss	☐	☐	
Heart Attack	☐	☐		Thyroid Disorder	☐	☐	
Heart Disease	☐	☐					

GENERAL	Yes	No	GENITOURINARY	Yes	No
Weight Change	☐	☐	Urinary Pain	☐	☐
Appetite Change	☐	☐	Change in Urinary System	☐	☐
Energy Level Change	☐	☐			
HEENT	**Yes**	**No**	**GYNECOLOGICAL**	**Yes**	**No**
Headaches	☐	☐	Last menstrual Period (Date):_____	☐	☐
Eyes	☐	☐	Hysterectomy	☐	☐
Ears	☐	☐	Number of Pregnancies: _____	☐	☐
Nose	☐	☐	Number of Children: _____	☐	☐
Throat	☐	☐	Vaginal Discharge	☐	☐
NECK	**Yes**	**No**	**NEUROLOGICAL**	**Yes**	**No**
Swelling	☐	☐	Weakness in Arms/Legs	☐	☐
Tenderness	☐	☐	Dizziness/Fainting	☐	☐
Goiter	☐	☐	Stroke/TIA	☐	☐
CHEST	**Yes**	**No**	**EXTREMITIES**	**Yes**	**No**
Pain	☐	☐	Swelling of Hands/Feet	☐	☐
Pressure	☐	☐	Varicose Veins	☐	☐
Racing Heart (Palpitations)	☐	☐	Leg Cramps	☐	☐
BREASTS	**Yes**	**No**	**SKIN**	**Yes**	**No**
Tenderness	☐	☐	Rashes	☐	☐
Lumps	☐	☐	History of Skin Cancer	☐	☐
LUNGS	**Yes**	**No**	**MUSCULOSKELETAL**	**Yes**	**No**
Chronic Cough	☐	☐	Joint Pain or Swelling	☐	☐
Shortness of Breath	☐	☐	Rheumatoid Arthritis	☐	☐
Blood in Sputum	☐	☐	Low Back Pain	☐	☐
DIGESTIVE SYSTEM	**Yes**	**No**	**PSYCHOLOGICAL**	**Yes**	**No**
Abdominal Pain	☐	☐	Depression	☐	☐
Nausea	☐	☐	Anxiety	☐	☐
Change in Bowel Habits	☐	☐	Sexual Difficulties	☐	☐
Black Tarry Stool	☐	☐	Abuse by Spouse or Other	☐	☐
Red Blood in Stool	☐	☐	Alcohol or Drug Addiction	☐	☐

LIST OTHER PROBLEMS

SURGICAL PROCEDURES		
Type of Surgery	**Year**	**Comments**

SOCIAL AND OCCUPATIONAL HISTORY

Hand dominance: ☐ Right ☐ Left Ambidextrous (both): ☐ Yes ☐ No

Smoking/Tobacco Use: ☐ Yes ☐ No Formerly:_____ Year Quit: _____

Type of Tobacco Product: _____

Units/packs per day:_____ Number of Years: _____

Alcohol Use: ☐ Yes ☐ No Formerly: _____ Year Quit: _____

Type of Alcohol: _____ Frequency: _____ Amount per Day: _____

History of DUI(s): ☐ Yes ☐ No 12-Step Groups? ☐ Yes ☐ No

Current or previous substance use: Marijuana: ☐ Yes ☐ No Cocaine: ☐ Yes ☐ No Other:_____

Toxic Environmental or Occupational Exposures: _____

MEDICATION / ALLERGIES

Medications: Please list all medications currently taken, amounts, and time taken.
(Include all injections, inhalers, eye medications, vitamins/supplements)

Medication Name	MG	Dose	How Often?
Injections	**MG**	**Dose**	**How Often?**
Inhalers	**MG**	**Dose**	**How Often?**
Vitamins / Supplements	**MG**	**Dose**	**How Often?**

MEDICATION / ALLERGIES

Medications: Please list all medications currently taken, amounts, and time taken.
(Include all injections, inhalers, eye medications, vitamins/supplements)

Allergies / Drug / Medication	Reaction	Year
Foods / Other Allergies	**Reaction**	**Year**

FAMILY HISTORY

Patient adopted? ☐ Yes ☐ No Information about parents not available? ☐ Yes ☐ No

Family memory problems or dementia (describe): _____

_____

Cholesterol problems:	☐ Father	☐ Mother	☐ Maternal Aunt	☐ Maternal Uncle	☐ Paternal Aunt	☐ Paternal Uncle	☐ Son	☐ Daughter
Heart Disease:	☐ Father	☐ Mother	☐ Maternal Aunt	☐ Maternal Uncle	☐ Paternal Aunt	☐ Paternal Uncle	☐ Son	☐ Daughter
Asthma/emphysema:	☐ Father	☐ Mother	☐ Maternal Aunt	☐ Maternal Uncle	☐ Paternal Aunt	☐ Paternal Uncle	☐ Son	☐ Daughter
Anxiety Disorder:	☐ Father	☐ Mother	☐ Maternal Aunt	☐ Maternal Uncle	☐ Paternal Aunt	☐ Paternal Uncle	☐ Son	☐ Daughter
Sleep Disorder:	☐ Father	☐ Mother	☐ Maternal Aunt	☐ Maternal Uncle	☐ Paternal Aunt	☐ Paternal Uncle	☐ Son	☐ Daughter
High Blood Pressure:	☐ Father	☐ Mother	☐ Maternal Aunt	☐ Maternal Uncle	☐ Paternal Aunt	☐ Paternal Uncle	☐ Son	☐ Daughter
Stroke:	☐ Father	☐ Mother	☐ Maternal Aunt	☐ Maternal Uncle	☐ Paternal Aunt	☐ Paternal Uncle	☐ Son	☐ Daughter
Thyroid disorder:	☐ Father	☐ Mother	☐ Maternal Aunt	☐ Maternal Uncle	☐ Paternal Aunt	☐ Paternal Uncle	☐ Son	☐ Daughter
Bipolar disorder:	☐ Father	☐ Mother	☐ Maternal Aunt	☐ Maternal Uncle	☐ Paternal Aunt	☐ Paternal Uncle	☐ Son	☐ Daughter
Diabetes:	☐ Father	☐ Mother	☐ Maternal Aunt	☐ Maternal Uncle	☐ Paternal Aunt	☐ Paternal Uncle	☐ Son	☐ Daughter
Parkinsonism:	☐ Father	☐ Mother	☐ Maternal Aunt	☐ Maternal Uncle	☐ Paternal Aunt	☐ Paternal Uncle	☐ Son	☐ Daughter
Cancer:	☐ Father	☐ Mother	☐ Maternal Aunt	☐ Maternal Uncle	☐ Paternal Aunt	☐ Paternal Uncle	☐ Son	☐ Daughter
Depression:	☐ Father	☐ Mother	☐ Maternal Aunt	☐ Maternal Uncle	☐ Paternal Aunt	☐ Paternal Uncle	☐ Son	☐ Daughter