LEXINGTON MEDICAL CENTER
Lexington

811 West Main Street, Suite 205 • Lexington, SC 29072
Phone: (803) 358-6115 • **FAX:** (803) 358-6117

Lexington Medical Center

Patient History

Name: _____ ☐ Male ☐ Female **DOB:** _____

Referring Physician: _____ Date of next physician visit: _____

Date of injury: _____ Are you currently working? ☐ Yes ☐ No

Body part(s) being treated: _____

Have you had any of the following tests for this condition? ☐ MRI ☐ X-ray ☐ CAT scan ☐ Bone scan ☐ Other: _____

Check which apply to your symptoms:

☐ Motor vehicle accident
☐ Work related accident
☐ Athletic/Recreational injury
☐ Recurrence of previous injury
☐ Injury related to falling
☐ Injury related to lifting
☐ Cause unknown
☐ Other: _____

Have you had a related surgery/operation? ☐ Yes ☐ No If yes, date of surgery? _____

Other surgeries (with dates): _____

Please check if your have ever been diagnosed with any of the following:

☐ Asthma
☐ Cancer
☐ Diabetes
☐ Depression
☐ Difficulty hearing
☐ Dizziness
☐ Fibromyalgia /Chronic Fatigue Syndrome
☐ Hepatitis
☐ GI Problems
☐ High Blood Pressure
☐ Headaches
☐ Heart disease
☐ Kidney disease
☐ Liver disease
☐ Osteoporosis
☐ Pacemaker/Defibrillator
☐ Respiratory problems
☐ Seizures
☐ Smoker
☐ Stroke / CVA
☐ Thyroid disease
☐ Tuberculosis

Other: _____

Is there any other information regarding your past medical history we should know about? ☐ Yes ☐ No
If yes, please list/describe: _____

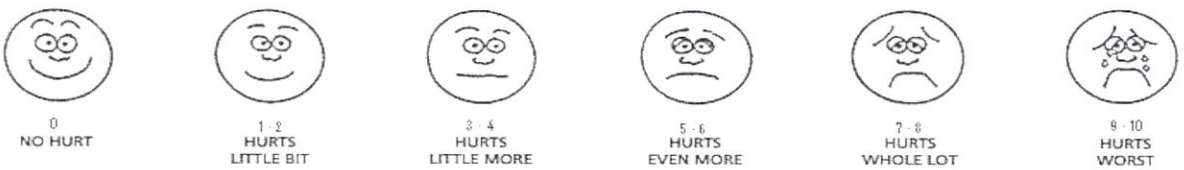
Medications (including injections) :
☐ I <u>am</u> taking medications (please list below **or** provide a copy to staff). ☐ I <u>am not</u> taking medications at this time.

_____ _____ _____
_____ _____ _____

Drug and/or Food Allergies: _____
Latex / Rubber/ Elastic Sensitivity: ☐ Yes ☐ No

Pain scale: Please circle the number under a face that best represents your worst level of pain.

Location(s) of Pain: _____



Signature: _____ Date: _____

If other than patient: _____ Relationship: _____

CONTINUED ON OTHER SIDE

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Not Employed ☐ Student ☐ Disabled ☐ Self Employed

Employer: _____ Phone: _____

Address: _____ Zip: _____

Insurance Card Holder:
Name: _____ SS#: _____ DOB: _____

Responsible Party:
Name: _____ SS#: _____ DOB: _____

Emergency Contact:
Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Medicare patients only:

Retirement Date: _____ Spouse's Retirement Date: _____

1. Are benefits based on ☐ Age ☐ Disability or ☐ End-Staged Renal Disease? (Check all that apply)
2. Are you receiving black lung benefits? ☐ Yes ☐ No
3. Do you work? ☐ Yes ☐ No
4. Does your spouse work? ☐ Yes ☐ No
5. Are you covered by a family members insurance? ☐ Yes ☐ No
6. Is this visit related to ☐ work ☐ non-work ☐ auto accident or ☐ none of these? (Check one)

Self-pay patients only:

1. Have you applied for other health insurance? ☐ Yes ☐ No
2. Would you like any information on how to do so? ☐ Yes ☐ No
3. Would you like to speak with a Financial Counselor? ☐ Yes ☐ No