Riverside
SURGICAL GROUP
A Lexington Medical Center Physician Practice

Lexington Medical Park 2
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RiversideSurgical.com

Medical History

Patient's Full Name _____ Age _____ Date _____

Referring Doctor _____ Regular Doctor _____

Reason for Visit _____

Past Medical History: Do you have or have you ever been treated for (check all that apply):

CARDIAC
- ❑ Heart Attack
- ❑ Coronary artery disease
- ❑ High Blood Pressure
- ❑ Heart Failure
- ❑ Irregular heart beat
- ❑ High cholesterol

PULMONARY
- ❑ Emphysema
- ❑ Asthma
- ❑ Chronic Bronchitis
- ❑ Sleep Apnea

GASTROINTESTINAL
- ❑ Hepatitis
- ❑ Chronic heart burn
- ❑ Ulcers
- ❑ Diverticulosis
- ❑ Polyps

GENITOURINARY
- ❑ Kidney failure
- ❑ Kidney stones
- ❑ Kidney infections
- ❑ Chronic urinary infection

ENDOCRINE
- ❑ Diabetes
- ❑ Thyroid problems

NEUROLOGICAL
- ❑ Stroke
- ❑ Seizures

HEMATOLOGICAL
- ❑ Anemia
- ❑ Blood clots
- ❑ HIV

MUSCULOSKELETAL
- ❑ Arthritis – Joints
- ❑ Arthritis – Back
- ❑ Disc problems – Back
- ❑ Osteoporosis
- ❑ Gout
- ❑ Varicose Veins

PSYCHOLOGICAL
- ❑ Depression

EYES
- ❑ Glaucoma
- ❑ Blindness

OTHER
- ❑ Lupus
- ❑ MRSA
- ❑ _____

CANCER
- ❑ Type _____
- ❑ Date _____

Past Surgical History: Please include date.

- ❑ Appendix _____
- ❑ Back (Disc) _____
- ❑ C-Section _____
- ❑ Heart Bypass _____
- ❑ Hernia _____
- ❑ Hysterectomy (Uterus) _____
- ❑ Gallbladder _____
- ❑ Tonsils _____
- ❑ Other _____

Medical Allergies: Please include reaction.

_____
_____
_____
_____
_____

Family Medical History: Please list medical problems, not names.

Father _____ Mother _____

Grandfather _____ Grandmother _____

Brother _____ Sister _____

_____ _____

_____ _____

Social History:

MARITAL STATUS: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Current Employment:_____

_____

Retired: ❑ Yes ❑ No

Tobacco Use: ❑ None ❑ Cigarettes ❑ Cigars ❑ Pipes

PPD _____ No. Years _____ Quit Date _____

Alcohol Use

❑ Yes ❑ No Amount _____

Will you accept blood products? ❑ Yes ❑ No

Physical Activity: ❑ Regularly ❑ Occasionally ❑ Rarely

Type of activity _____

Review of Symptoms: Do you have or have you ever been treated for (check all that apply)?

HEENT
- ❑ Frequent headache
- ❑ Change in vision
- ❑ Dizziness
- ❑ Change in hearing
- ❑ Ringing in ears

CARDIAC
- ❑ Chest pain
- ❑ Racing pulse
- ❑ Leg swelling
- ❑ Lightheadedness

PULMONARY
- ❑ Shortness of Breath
  - ❑ at rest ❑ with exertion
- ❑ Cough
- ❑ Wheezing

GASTROINTESTINAL
- ❑ Nausea / Vomiting
- ❑ Difficulty swallowing
- ❑ Indigestion
- ❑ Diarrhea
- ❑ Constipation
- ❑ Blood in stool

GENITOURINARY
- ❑ Blood in urine
- ❑ Painful urination
- ❑ Night time urination
- ❑ Incontinence

MUSCULOSKELETAL
- ❑ Muscle weakness
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Back pain

GENERAL
- ❑ Fever / chills
- ❑ Weight loss / gain
- ❑ Night sweats
- ❑ Hotter than usual
- ❑ Colder than usual
- ❑ Easy bruising
- ❑ Easy bleeding
- ❑ Daytime sleepiness
- ❑ Snoring
- ❑ Waking up at night

FOR OFFICE USE ONLY

Physical Exam

Height_____ Weight_____ BMI_____ BP_____ HR_____

General: ❑ WNL _____ Neck: ❑ WNL _____ Lungs: ❑ WNL _____ Ext: ❑ WNL _____

HEENT: ❑ WNL _____ Heart: ❑ WNL _____ Abd: ❑ WNL _____