Southern Surgical GROUP
A Lexington Medical Center Physician Practice

Lexington Medical Center Park 2
146 East Hospital Drive, Suite 310, West Columbia, SC 29169
Phone: (803) 936-8901 • Fax: (803) 796-4217

Lexington Medical Center

Medical History

Patient Name: _____ Date : _____

MR#: _____ Age: _____ Primary Care MD: _____

Referring MD: _____ Cardiologist: _____

Reason for Visit: _____

Allergies (include medications, foods, and topical such as tape or latex and TYPE OF REACTION): _____

_____

_____

PAST MEDICAL HISTORY/ROS

CARDIAC/VASCULAR PROBLEMS:

Leg pain when walking	☐ Yes ☐ No
Mitral valve prolapse	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No
Coronary artery disease	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No
Congestive heart failure	☐ Yes ☐ No
Irregular heart beat	☐ Yes ☐ No
High cholesterol	☐ Yes ☐ No
Stents in any vessel	☐ Yes ☐ No

GASTROINTESTINAL PROBLEMS:

Hepatitis	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No
Constipation/diarrhea	☐ Yes ☐ No
Hiatal hernia	☐ Yes ☐ No
Diverticulosis	☐ Yes ☐ No
Polyps	☐ Yes ☐ No
Bleeding (stomach, intestine, rectum)	☐ Yes ☐ No

PULMONARY PROBLEMS:

Coughing up blood	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No
Chronic bronchitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No

ENDOCRINE PROBLEMS:

Diabetes	☐ Yes ☐ No
How long diabetic? _____	
Thyroid problems	☐ Yes ☐ No
Recent weight change	☐ Yes ☐ No

NEUROLOGICAL PROBLEMS:

Stroke	☐ Yes ☐ No
Seizures	☐ Yes ☐ No

HEMATOLOGIC:

Anemia	☐ Yes ☐ No
Blood clots	☐ Yes ☐ No
Bleeding disorders	☐ Yes ☐ No

CANCER: ☐ Yes ☐ No

Type of cancer: _____

RENAL/GENITOURINARY PROBLEMS:

Blood in urine	☐ Yes ☐ No
Kidney disease	☐ Yes ☐ No
Kidney infections/stones	☐ Yes ☐ No

MUSCULOSKELETAL:

Arthritis/bursitis	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No
Varicose veins/phlebitis	☐ Yes ☐ No
Leg Ulcers	☐ Yes ☐ No

PSYCH:

Depression	☐ Yes ☐ No
Sleep disturbances	☐ Yes ☐ No

EYES:

Glaucoma	☐ Yes ☐ No
Vision problems	☐ Yes ☐ No
Blurring/double vision	☐ Yes ☐ No

GENERAL:

Fever	☐ Yes ☐ No
Chills	☐ Yes ☐ No
Night sweats	☐ Yes ☐ No

PAST SURGICAL HISTORY

_____

_____

_____

FAMILY HISTORY (age and cause of death/medical problems – DO NOT give names)

Father: _____ Mother: _____

_____ _____

Brother(s): _____ Sister(s): _____

_____ _____

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Current Employment: _____

Retired: ☐ Yes ☐ No Tobacco: ☐ Yes ☐ No ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless

Quit date: _____ PPD: _____ No. years: _____ Alcohol: ☐ Yes ☐ No Amount: _____

Will you allow transfusion of blood or blood products if your doctor deems it to be medically necessary? ☐ Yes ☐ No

Reviewed	_____	_____	_____	_____	_____	_____
Date/Initial	_____	_____	_____	_____	_____	_____