LEXINGTON FAMILY PRACTICE Forest Acres
A Lexington Medical Center Physician Practice

5143 Forest Drive, Suite 200, Columbia, SC 29206
(803) 314-9120 • Fx: (803) 314-9121

Lexington Medical Center

Health Profile

Name:_____ Date:_____

FAMILY HISTORY

FAMILY Print the names of your relatives, living or deceased, in the list below. If there is not enough space, place an (X) here:	**YEAR OF BIRTH / HEALTH STATUS** Give the year of birth for all your relatives listed at the left and mark an (X) to indicate whether their health is good or poor.			**ILLNESSES** Place an (X) in the appropriate column for any illness that you or the relatives listed at the left have now or have had.					**DEATHS** If a relative you have listed has died, write the cause of death and the age at death in the columns below.	
	Year of Birth	Good	Poor	Heart Attacks	High Blood Pressure	Tuberculosis	Cancer	Diabetes	Cause of Death	Age
Father:										
Mother:										
Brothers and/or Sisters:										
Spouse:										
Children:										
Grandparents: (Mark an (X) for illnesses only.)										

LIFESTYLE

☐ Yes ☐ No Do you use tobacco regularly?
☐ Cigarette ☐ Pipe ☐ Cigar ☐ Chew

If yes, how long? _____

How much? _____

☐ Yes ☐ No Do you drink over 6 cups of coffee a day?

☐ Yes ☐ No Do you drink alcohol regularly?
☐ 1 oz per day ☐ 2 oz per day
☐ 4 oz per day ☐ Over 4 oz per day
Beer: ☐ 1 bottle per day ☐ 2 bottles per day
☐ Over 2 bottles per day

If you drink alcohol:
☐ Yes ☐ No Have you ever felt the need to cut down on your drinking?
☐ Yes ☐ No Have you felt annoyed by criticism about your drinking?
☐ Yes ☐ No Have you had guilty feelings about your drinking?

☐ Yes ☐ No Do you wear a seat belt regularly?

☐ Yes ☐ No Are you coping well with your stress?

☐ Yes ☐ No Do you often feel depressed or down for more than a few days with no apparent cause?

☐ Yes ☐ No Are you employed?
If yes, what is your occupation?_____

How many hours do you work per week?_____

☐ Yes ☐ No Do you regularly exercise? How?_____

☐ Yes ☐ No Do you have any dietary restrictions?
If so, what? _____

☐ Yes ☐ No Are you up to date on immunizations?
When was your last tetanus shot? _____
Flu shot?_____ Pneumonia shot? _____

How many meals do you eat per day?_____

How many hours of sleep do you get per night?_____

What are your major hobbies and recreational activities?_____

_____

How much recreational time do you allow yourself per day?_____

_____

MEDICATIONS

List medications that you take (dose and frequency):

_____

_____

List allergies to any medications:

_____

_____

PAST HISTORY

List any surgeries and the year of occurance: _____

_____

_____

List any significant diseases and the year of occurrence: _____

_____

_____

List any serious injuries or accidents and the year of occurrence:_____

_____

_____

REVIEW OF SYSTEMS

SKIN

Have you had any skin trouble – rashes, eczema, acne, skin cancer?	☐ Frequently	☐ Occasionally	☐ Never
Have any skin growths or moles increased in size or changed color?	☐ Yes	☐ No	

List any other skin problems:_____

HEAD

Do you have severe headaches?	☐ Frequently	☐ Occasionally	☐ Never
Do you have episodes of dizziness or numbness, tingling or weakness in any part of your body?	☐ Frequently	☐ Occasionally	☐ Never

List any other head problems:_____

EYES - EARS

Do you have any trouble hearing?	☐ Frequently	☐ Occasionally	☐ Never
Do you wear glasses or contacts?	☐ Frequently	☐ Occasionally	☐ Never
Do you see double or does your eyesight black out?	☐ Frequently	☐ Occasionally	☐ Never

When was the last time you had your eyes examined by an optometrist/ophthalmologist?_____

List any other eye or ear problems:_____

NOSE

Do you have any problems with allergies, sneezing or sinuses?	☐ Frequently	☐ Occasionally	☐ Never

List any other nose problems:_____

MOUTH

List any mouth problems:_____

CONTINUED ON NEXT PAGE

RESPIRATORY (CHEST)			
Do you have asthma?	☐ Frequently	☐ Occasionally	☐ Never
Do you cough?	☐ Frequently	☐ Occasionally	☐ Never
Do you cough up sputum or phlegm?	☐ Frequently	☐ Occasionally	☐ Never
Have you coughed up blood?	☐ Frequently	☐ Occasionally	☐ Never
Have you had tuberculosis or lived with someone who had tuberculosis?	☐ Yes	☐ No	
Do you get unusually short of breath with activity? Give an example:_____	☐ Frequently	☐ Occasionally	☐ Never

List any other respiratory (chest) problems:_____

CARDIOVASCULAR (HEART)			
Have you had high blood pressure?	☐ Yes	☐ No	
Have you had a heart attack?	☐ Yes	☐ No	
Do you have pains in your chest (angina) when walking, working or climbing stairs?	☐ Frequently	☐ Occasionally	☐ Never
Does your heart beat irregularly or rapidly?	☐ Frequently	☐ Occasionally	☐ Never
Do you have to prop up in bed at night to breathe?	☐ Frequently	☐ Occasionally	☐ Never
Do you have cramping in your calves or thighs after walking?	☐ Frequently	☐ Occasionally	☐ Never

List any other cardiovascular (heart) concerns:_____

GASTROINTESTINAL (STOMACH)			
Have you had stomach ulcers?	☐ Yes	☐ No	
Have you had gallstones or gallbladder trouble?	☐ Yes	☐ No	
Have you had jaundice (yellow eyes) or hepatitis?	☐ Yes	☐ No	
Have you had rectal hemorrhoids?	☐ Yes	☐ No	
Do you experience rectal bleeding?	☐ Frequently	☐ Occasionally	☐ Never
Do you experience constipation?	☐ Frequently	☐ Occasionally	☐ Never
Do you experience indigestion?	☐ Frequently	☐ Occasionally	☐ Never

List any other gastrointestinal (stomach) problems:_____

GENITO-URINARY (KIDNEY)			
Have you had blood in your urine?	☐ Frequently	☐ Occasionally	☐ Never
Do you have trouble starting or stopping your stream?	☐ Frequently	☐ Occasionally	☐ Never
Do you have to get up more than once during the night to urinate?	☐ Frequently	☐ Occasionally	☐ Never
Do you lose control of your bladder?	☐ Frequently	☐ Occasionally	☐ Never
Do you use birth control? Which type: _____	☐ Yes	☐ No	

List any other genito-urinary (kidney) problems:_____

BONES – JOINT – MUSCLES			
Are your joints painfully swollen or stiff?	☐ Frequently	☐ Occasionally	☐ Never
Have you had serious back trouble?	☐ Frequently	☐ Occasionally	☐ Never
Do you have arthritis?	☐ Yes	☐ No	

List any other bone, joint, or muscle problems:_____

CONTINUED ON BACK PAGE

ENDOCRINE (GLANDS)			
Have you had any thyroid problems?	☐ Yes	☐ No	
Are you hungry or thirsty at all times?	☐ Frequently	☐ Occasionally	☐ Never
Do you urinate more than you think you should?	☐ Frequently	☐ Occasionally	☐ Never
Have you had gout?	☐ Yes	☐ No	
Do you have diabetes?	☐ Yes	☐ No	
Have you gained or lost weight recently without trying? If so, how much? _____	☐ Yes	☐ No	

List any other endocrine (glands) problems:_____

GENERAL		
Have you noticed any swelling or a lump in your neck, armpits or groin?	☐ Yes	☐ No
Do you have trouble falling asleep or staying asleep?	☐ Yes	☐ No
Have you had a nervous breakdown?	☐ Yes	☐ No

ADDITIONAL QUESTIONS FOR MEN ONLY		
Have you ever had any prostate gland trouble?	☐ Yes	☐ No
Do you have trouble with erections?	☐ Yes	☐ No

List any other male problems:_____

ADDITIONAL QUESTIONS FOR WOMEN ONLY			
Are your periods irregular?	☐ Frequently	☐ Occasionally	☐ Never
Do you have a lot of cramping with your period?	☐ Frequently	☐ Occasionally	☐ Never
Have you, within the past year, had vaginal bleeding other than at the time of a period?	☐ Yes	☐ No	
Have you had a lump in your breast?	☐ Yes	☐ No	
Have you ever been pregnant? If yes, how many times? _____ Number of living children: _____	☐ Yes	☐ No	

When was the first day of your last period? _____ When was your last pap smear? _____

List any other female problems:_____

DENTAL			
Have you had any pain in your jaw joints (pain in front of your ear)?	☐ Frequently	☐ Occasionally	☐ Never

When was your last dental exam? _____

ADDITIONAL INFORMATION

Please list any other concerns or problems:

_____

_____

_____

_____

_____

_____

_____