



# Lexington Clinic

## First Choice Walk-In Care Information For Your Provider

Patient Please Complete <b>This Side</b> Only / Please Print			
Patient Last Name	Patient First Name	Middle Initial	Sex
Who is your personal physician?	<b>Reason you need to be seen today?</b> (symptoms)		
<b>List all your medications: (list all pills, vitamins, shots, herbs, sprays, patches, birth control, over-the-counter and non-prescription drugs). List dosages if you know them.</b>			
Medication: _____	Reason: _____	_____	_____
Medication: _____	Reason: _____	_____	_____
Medication: _____	Reason: _____	_____	_____
Medication: _____	Reason: _____	_____	_____
Medication: _____	Reason: _____	_____	_____
Medication: _____	Reason: _____	_____	_____
Medication: _____	Reason: _____	_____	_____
<b>Are you allergic to any drugs?</b> If so, list them and the reaction you had.			
<b>List the surgeries you have had and what year they were performed:</b>			
<b>Do you have or ever had any of the following conditions?</b> Circle all that apply.			
High Blood Pressure	Stroke	Diabetes	Thyroid
Asthma	Liver Disease	Kidney Disease	COPD (Emphysema)
Chronic pain	None	Cancer	Other _____
Heart Disease	Ulcer		
<b>Family History: Have your parents, grandparents, brothers or sisters been treated for any of the following?</b> Circle all that apply.			
High Blood Pressure	Stroke	Diabetes	Thyroid
Heart Disease	Cancer	Other _____	None
<b>Do you smoke?</b>	How much?	<b>Are you exposed to smoke routinely?</b>	<b>Do you ever drink alcohol?</b>
<b>Females:</b> date your last menstrual cycle began:		<b>Type of birth control you use</b> (condom, pill, spermicide, IUD, shots, patch, rhythm, surgery):	
Phone number we can call about visit (if different from home):			
May we leave voice message at this number?			Doctor Initials
<b>Patient/Guardian Signature</b> _____ <b>Date:</b> _____ <b>Time:</b> _____			
Relationship to Patient: _____			