Confidential Health Assessment
Lexington Internal Medical Care
2 Cherry Street Lexington, NC 27292
Phone:336-249-2500 Fax: 336-249-2555

Patient Name________________________ Date of Birth____________

Address____
(Street) (City) (State) (Zip)

Home Phone #______________________ Work Phone #_______________

Cell Phone #_________________ Social Security #_________________

Marital Status: S M D W SEP _____Male ______Female

Type of Insurance_________________ Last Doctor Seen______________

Present Illness
Please list any problems or concerns for which you are being treated:

1)______________________________ 2)__________________________

3)______________________________ 4)___________________________

Allergies
This is any reaction you have had to meds, foods, smoke, pollen, etc
1)_______________________________ 2)___________________________

3)_______________________________ 4)___________________________

Medications
List all medications you are taken on a regular basis(over the counter, vitamins, etc)

1)_______________________________ 2)___________________________

3)_______________________________ 4)___________________________

5)________________________________ 6)__________________________

Past Medical History

List all hospitalizations, surgeries, or any ongoing medical problems you had(Ex. Blood pressure, high cholesterol, diabetes, cancer, etc.)

1)_____________________________ 2)__________________________

3)_____________________________ 4)___________________________

When was your last:

Tetanus___________________ TB Test______________

Flu Vaccine_______________ Pneumonia Vaccine_____________

Pap Smear_____________ Self Breast Exam_______Mammogram______

Prostate Check____________ Testes self exam_____________

Personal History

Alcohol use_________ Tobacco use___________

Family History

Have any of your blood relatives had?(Siblings, mother, father, and grandparents) Please check all that apply.

High Blood Pressure________
Heart Disease________
Diabetes_______
Kidney Disease_______
Cancer________
Stroke_______
Alcoholism_______
Suicide________

Other diseases, neurological, and blood disorders not listed above:_________________.

Patient Signature_______________________ Date_________________