LEXINGTON
NEUROLOGY
A Part of Lexington Clinic

David M. Blake, MD

Dear Patient,

Welcome to our office! In order to make the check-in process more efficient, please complete the forms included in this online packet prior to your visit and bring it with you to your appointment.

When you arrive, **please register on the first floor** of Lexington Clinic.

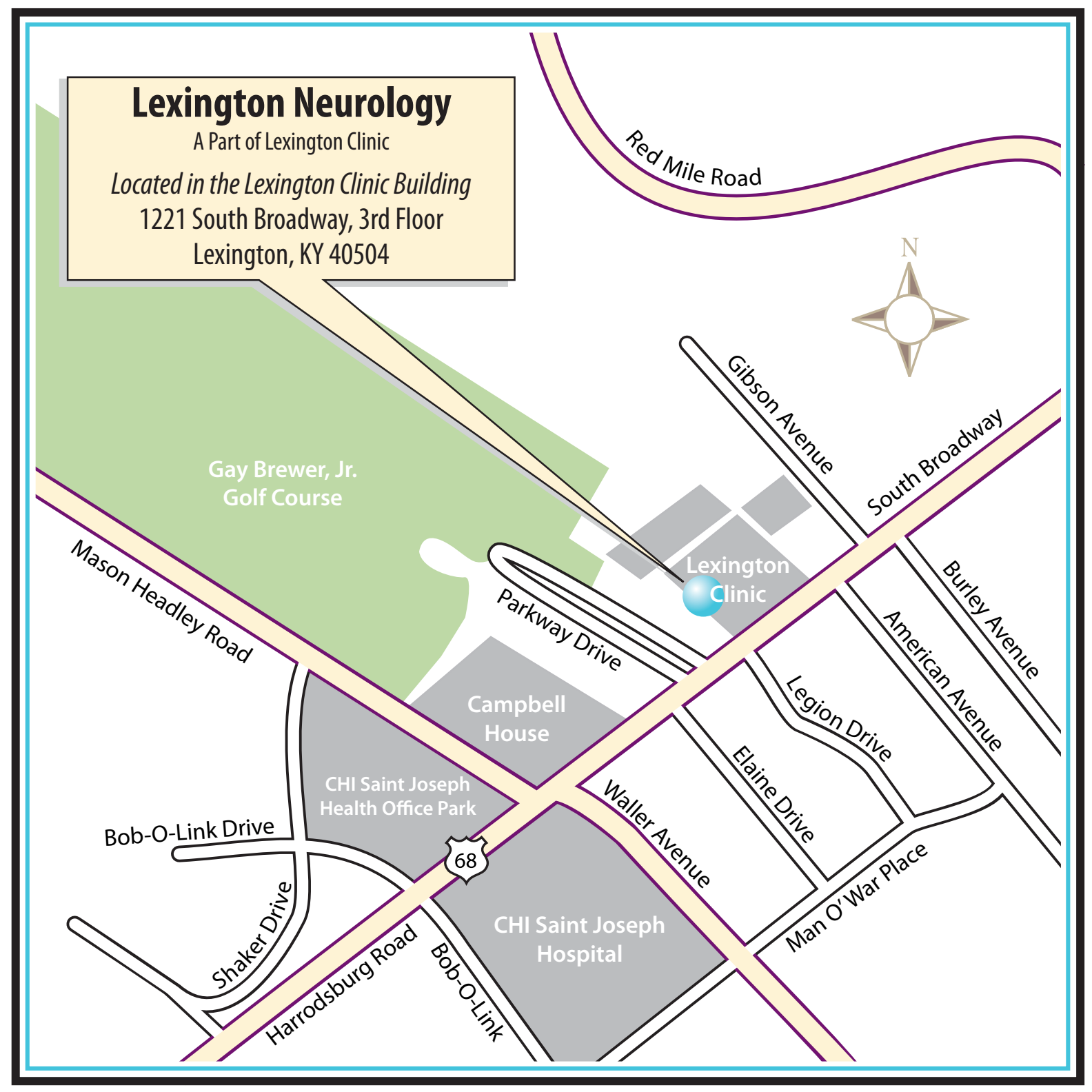
Please bring these to your appointment:

- copies of your completed online forms
- insurance card(s),
- a photo ID
- any discs that may need to be evaluated.

Your insurance co-payment will be due at the time of service.

For a listing of insurances that we accept, please visit LexingtonClinic.com/insurance.html. Thank you and we look forward to meeting you.

Best regards,
Dr. David Blake


Lexington Neurology
A Part of Lexington Clinic
Located in the Lexington Clinic Building
1221 South Broadway, 3rd Floor
Lexington, KY 40504
Red Mile Road
N
Gibson Avenue
South Broadway
Gay Brewer, Jr.
Golf Course
Lexington
Clinic
Parkway Drive
Mason Headley Road
Burley Avenue
American Avenue
Legion Drive
Elaine Drive
Campbell
House
CHI Saint Joseph
Health Office Park
Waller Avenue
Bob-O-Link Drive
68
Man O' War Place
Shaker Drive
CHI Saint Joseph
Hospital
Harrodsburg Road
Bob-O-Link

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Date _____

Patient Name _____
First Middle Last

Birth Date _____ Age _____ ☐ Male ☐ Female

Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ Zip _____

Email Address _____

Race _____ Ethnicity _____ Language _____

Employment Status ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

Occupation _____

Current Employer _____

Emergency Contact Person _____

Relationship _____ Phone _____

Primary Care Physician _____ Who referred you to us? _____

Reason for Today's Visit _____

Pharmacy Name _____

Pharmacy Address _____ Pharmacy Phone _____

Current Medications

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

Name _____ Dose _____ Frequency _____

(continued on other side)

Lexington Clinic | 1221 South Broadway, 3rd Floor | Lexington, KY 40504 | p. 859.258.4173 | f. 859.258.4119

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ALLERGIES
Please indicate any allergies and describe reaction. If you have no known allergies please check *NONE*.

- ☐ Codeine
- ☐ Sulfa
- ☐ Dilantin
- ☐ Aspirin
- ☐ Seafood
- ☐ X-ray Dye
- ☐ Penicillin
- ☐ Morphine
- ☐ Iodine
- ☐ Shellfish
- ☐ Other _____
- ☐ NONE

FAMILY HISTORY
Please indicate if any family member(s) have had this condition and indicate which member by using the following key:

F - Father M - Mother S - Sister B - Brother GF - Grandfather GM - Grandmother

- High Blood Pressure _____
- Heart Disease _____
- Stroke _____
- Cancer _____
- Diabetes _____
- Obesity _____
- OTHER (Please list) _____
  _____

PAST SURGICAL HISTORY (Write in year for all that apply)

	YEAR
☐ NO PRIOR SURGERY	_____
☐ Appendectomy	_____
☐ Tonsillectomy	_____
☐ Carpel Tunnel Release	_____
☐ Back Surgery	_____
☐ Neck Surgery	_____
☐ Knee Surgery	_____
☐ Hip Replacement	_____
☐ Coronary Artery Bypass Graft (CABG)	_____
☐ Pacemaker	_____
☐ Stent *Location?* _____	_____
☐ Shunt *Location?* _____	_____
☐ Pain Pump	_____
☐ OTHER (Please list)	_____

*If you have a card for an implanted device please provide it to us at check in

PAST MEDICAL HISTORY (Check all that apply)

- ☐ Alzheimer's
- ☐ Anxiety
- ☐ Arthritis
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Migraines
- ☐ Epilepsy
- ☐ Headache
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Neurological Disorders
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disorder

OTHER (please list) _____

IMMUNIZATION HISTORY
If you refuse to receive vaccines please let us know so that we can notate your chart and eliminate the need to ask multiple times during your visit.

	DATE	GIVEN BY
☐ Influenza Immunization	_____	_____
☐ Pneumococcal Vaccination	_____	_____
☐ Hepatitis A or B Vaccination	_____	_____
☐ Shingles Vaccine	_____	_____

*If you receive vaccine from a location outside Lexington Clinic please have your pharmacy or provider fax your vaccine record to us at 859-260-7719 so we may update your medical record.

SOCIAL HISTORY

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of spouse _____

Live alone? ☐ No ☐ Yes

Do you smoke? ☐ No ☐ Yes

If yes, how long? _____ *Packs per day?* _____

Do you chew tobacco? ☐ No ☐ Yes

Do you use alcohol? ☐ No ☐ Yes *If yes, how often?*

- ☐ Monthly
- ☐ 2 to 4 times per month
- ☐ 2 to 3 times per week
- ☐ 4 or more times a week.

For how many years? _____

Do you use illicit drugs? ☐ No ☐ Yes

If yes, please list _____
_____

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