

Dear Patient,

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

Please bring these to your appointment:

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

If you are coming due to an abnormal scan and forget to bring your disc, we will most likely need to reschedule your appointment.

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

Gay Brewer, Jr.
Golf Course

Lexington
Clinic

Campbell
House

CHI Saint Joseph
Health Office Park

CHI Saint Joseph
Health Hospital

Lexington Neurology

CHI Saint Joseph Health Office Park, D-302
1451 Harrodsburg Road
Lexington, KY 40504



A Part of Lexington Clinic



Mason Headley Road

Parkway Drive

South Broadway

Legion Drive

Elaine Drive

Waller Avenue

Man O' War Place

Bob-O-Link Drive

Shaker Drive

Harrodsburg Road

Bob-O-Link Drive

Saint Joseph Drive

68

68

Clays Mill Road

LEXINGTON NEUROLOGY

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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 NEUROLOGY

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ALLERGIES

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

- | | |
|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Codeine | <input type="checkbox"/> X-ray Dye |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Dilantin | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Seafood | <input type="checkbox"/> Shellfish |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> 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 |
|--|-------|
| <input type="checkbox"/> NO PRIOR SURGERY | N/A |
| <input type="checkbox"/> Appendectomy | _____ |
| <input type="checkbox"/> Tonsillectomy | _____ |
| <input type="checkbox"/> Carpel Tunnel Release | _____ |
| <input type="checkbox"/> Back Surgery | _____ |
| <input type="checkbox"/> Neck Surgery | _____ |
| <input type="checkbox"/> Knee Surgery | _____ |
| <input type="checkbox"/> Hip Replacement | _____ |
| <input type="checkbox"/> Coronary Artery Bypass Graft (CABG) | _____ |
| <input type="checkbox"/> Pacemaker | _____ |
| <input type="checkbox"/> Stent Location? _____ | _____ |
| <input type="checkbox"/> Shunt Location? _____ | _____ |
| <input type="checkbox"/> Pain Pump | _____ |
| <input type="checkbox"/> 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)

- | | |
|---|---|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Hypertension | |

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 |
|---|-------|----------|
| <input type="checkbox"/> Influenza Immunization | _____ | _____ |
| <input type="checkbox"/> Pneumococcal Vaccination | _____ | _____ |
| <input type="checkbox"/> Hepatitis A or B Vaccination | _____ | _____ |
| <input type="checkbox"/> 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?

- | | |
|---|--|
| <input type="checkbox"/> Monthly | <input type="checkbox"/> 2 to 3 times per week |
| <input type="checkbox"/> 2 to 4 times per month | <input type="checkbox"/> 4 or more times a week. |

For how many years? _____

Do you use illicit drugs? No Yes

If yes, please list _____