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 them 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 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

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1221 South Broadway, 1st Floor
Lexington, KY 40504
Phone: 859.258.6000

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PATIENT HISTORY

Date _____

Patient Name _____
First Middle Last

Birth Date _____ Age _____ ☐ Male ☐ Female

Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ Zip _____

EmailAddress _____

Race _____ Ethnicity _____ Language _____

ALS or Translator needed? ☐ Yes ☐ No If yes, what 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 _____

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PATIENT HISTORY

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

- ☐ Codeine
- ☐ X-ray Dye
- ☐ Sulfa
- ☐ Penicillin
- ☐ Dilantin
- ☐ Morphine
- ☐ Aspirin
- ☐ Iodine
- ☐ Seafood
- ☐ 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	
☐ Pain Pump	
☐ Stent *Location?* _____	
☐ Shunt *Location?* _____	
☐ 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		
☐ COVID 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 3 times per week
- ☐ 2 to 4 times per month
- ☐ 4 or more times a week

For how many years? _____

Do you use illicit drugs? ☐ No ☐ Yes
If yes, please list _____
_____