Columbus Medical Clinic
Medical History Form

Patient Name: ___________________________________Date of Birth: ______________Today's Date: ________________

ALLERGIES
Allergies: ☐ No ☐ Yes, please list ____

CURRENT MEDICATIONS **(include over the counter medications, herbals, supplements, etc.)**

PERSONAL/FAMILY MEDICAL HISTORY

	Personal History	**Family History**	
Acid Reflux	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
Asthma	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
Cancer, Types_______________	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
Lung Disease (COPD)	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
CVA (Stroke)	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
Diabetes Mellitus	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
Headaches, migraine	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
High Cholesterol	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
Osteoarthritis	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
Osteoporosis	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
Other: ____________________	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
Other: ____________________	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
Other: ____________________	☐ Yes ☐ No	☐ Yes ☐ No	Family member: ____________________
Sexually Transmitted Disease Describe: __________________	☐ Yes ☐ No		
Environmental Exposure	☐ Yes ☐ No		
Advance Directives	**Living Will** ☐ **Yes** ☐ **No**	**Organ Donation** ☐ **Yes** ☐ **No**	**Durable Power of Attorney:** ☐ **Yes** ☐ **No** **Who?** ______________________

FOR WOMEN ONLY

GYNECOLOGICAL HISTORY

# Pregnancies: _________	# Live births: __________	# Miscarriages: __________	# Abortions: __________

# of Vaginal Deliveries: _____________ # of C-Section Deliveries: ___________	Pregnancy Complications: ☐ Yes ☐ No If yes, please list: ________________ ______________________________	Age at first Menstrual Period: _________ Age at Menopause: _________
Date of last Pap Smear: _____________ Results: ☐ Normal ☐Abnormal	Date of last mammogram: ____________ Results: ☐ Normal ☐Abnormal	Date of last Bone Density: ___________ Results: ☐ Normal ☐Abnormal

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HOSPITALIZATIONS		
Reason for Hospitalization	**Date of Hospitalization**	**Hospital/Physician**

SURGICAL HISTORY		
Type of Surgery	**Date of Surgery**	**Hospital/Physician**

Procedures (Colonoscopy, Catheterizations, etc.)	Date of Procedure	Hospital/Physician
Colonoscopy		
Heart Catheterization		
Other:		

FAMILY HISTORY				
	Alive?	**Birth Year**	**Age at Death**	**Cause of death**
Father	☐ Yes ☐ No			
Mother	☐ Yes ☐ No			

	How many?	# Alive	Birth Year(s)	If deceased, age and cause of Death
Brother(s)				
Sister(s)				
Children: *Sons*				
Daughters				

SOCIAL HISTORY	
Occupation:	
Marital Status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Hobbies/Recreation: (please list)	

		Frequency	Quantity	Type	For Past Use: Date Quit
Exercise:	☐ Yes ☐ No				
Tobacco:	☐Never ☐ Present ☐Past				
Alcohol:	☐Never ☐ Present ☐Past				
Caffeine:	☐ Yes ☐ No				
Drug Use:	☐Never ☐ Present ☐Past				

IMMUNIZATIONS

Date of Last Tetanus: _____________ Date of Last Pneumovac: _____________ Date of Last Flu Vaccine: ______________

Date of Last Shingles Vaccine: _________________

OTHER MEDICAL PROVIDERS		
Name:	Specialty:	Phone No.:
Name:	Specialty:	Phone No.:
Name:	Specialty:	Phone No.:

Signature: __________________________________Printed Name: ________________________________Date: ________________