**Columbus Medical Clinic Medical History Form**

Patient Name: Date of Birth: Today’s Date:

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| ***ALLERGIES*** |
| Allergies: No Yes, please list  |
| ***CURRENT MEDICATIONS* (include over the counter medications, herbals, supplements, etc.)** |
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| ***PERSONAL/FAMILY MEDICAL HISTORY*** |
|  | **Personal History** | **Family History** |
| Acid Reflux AsthmaCancer, Types  |  |  | Yes NoYes NoYes No |  | Yes NoYes NoYes No | Family member: Family member: Family member:  |
| Lung Disease (COPD)CVA (Stroke) Diabetes Mellitus |  |  |  | Yes NoYes NoYes No |  | Yes NoYes NoYes No | Family member: Family member: Family member:  |
| Headaches, migraine |  |  |  | Yes No |  | Yes No | Family member:  |
| Heart Disease |  |  |  | Yes No |  | Yes No | Family member:  |
| High Blood Pressure High CholesterolKidney Disease |  |  |  | Yes NoYes NoYes No |  | Yes NoYes NoYes No | Family member: Family member: Family member:  |
| Osteoarthritis |  |  |  | Yes No |  | Yes No | Family member:  |
| OsteoporosisOther:  |  |  | Yes NoYes No |  | Yes NoYes No | Family member: 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 |
| ***Continued on back side*** |

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| ***HOSPITALIZATIONS*** |
| **Reason for Hospitalization** | **Date of Hospitalization** | **Hospital/Physician** |
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| ***SURGICAL HISTORY*** |
| **Type of Surgery** | **Date of Surgery** | **Hospital/Physician** |
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|  |  |  |
|  |  |  |
| **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: