**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 Asthma  Cancer, Types | |  |  | Yes No  Yes No  Yes No |  | Yes No  Yes No  Yes No | Family member: Family member:  Family member: | | | |
| Lung Disease (COPD)  CVA (Stroke) Diabetes Mellitus |  |  |  | Yes No  Yes No  Yes No |  | Yes No  Yes No  Yes 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 Cholesterol  Kidney Disease |  |  |  | Yes No  Yes No  Yes No |  | Yes No  Yes No  Yes No | Family member: Family member:  Family member: | | | |
| Osteoarthritis |  |  |  | Yes No |  | Yes No | Family member: | | | |
| Osteoporosis  Other: | |  |  | Yes No  Yes No |  | Yes No  Yes 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 | |  | | |  | |  | | | | | | |
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|  | **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: