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: _____