

**Medical Information Summary for Central Ohio Medicine Patients**

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

**Please check all that apply to your Past Medical History:**

- |                         |                          |                         |                          |
|-------------------------|--------------------------|-------------------------|--------------------------|
| Recent weight change    | <input type="checkbox"/> | Headaches               | <input type="checkbox"/> |
| Difficulty seeing       | <input type="checkbox"/> | Difficulty hearing      | <input type="checkbox"/> |
| High blood pressure     | <input type="checkbox"/> | Low blood pressure      | <input type="checkbox"/> |
| Heart disease           | <input type="checkbox"/> | Swelling of ankles/feet | <input type="checkbox"/> |
| Asthma                  | <input type="checkbox"/> | Shortness of breath     | <input type="checkbox"/> |
| Diabetes                | <input type="checkbox"/> | Renal disease           | <input type="checkbox"/> |
| Abdominal Pain          | <input type="checkbox"/> | Trouble swallowing      | <input type="checkbox"/> |
| Change in bowel pattern | <input type="checkbox"/> | Heartburn               | <input type="checkbox"/> |
| Anemia                  | <input type="checkbox"/> | Dizziness               | <input type="checkbox"/> |
| Joint or muscle pain    | <input type="checkbox"/> | Depression/Anxiety      | <input type="checkbox"/> |
- Other: \_\_\_\_\_

**Women: please fill out the following and check all that apply:**

- |                                      |                          |                                |                          |
|--------------------------------------|--------------------------|--------------------------------|--------------------------|
| Hx of abnormal pap                   | <input type="checkbox"/> | Irregular periods              | <input type="checkbox"/> |
| Vaginal bleeding/discharge           | <input type="checkbox"/> | Hx of lumps/breast cancer      | <input type="checkbox"/> |
| History of STD's                     | <input type="checkbox"/> |                                |                          |
| Date of last menstrual period        | ____/____/____           | Date of last bone density scan | _____                    |
| Do you use birth control?            | Y N                      | What type?                     | _____                    |
| Number of pregnancies                | _____                    | Number of miscarriages         | _____                    |
| Date of last pap test                | ____/____/____           | Date of last mammogram         | ____/____/____           |
| Do you do monthly self breast exams? | Y N                      |                                |                          |

**Men: please check all that apply:**

- |                           |                          |                           |                          |
|---------------------------|--------------------------|---------------------------|--------------------------|
| Prostate problems         | <input type="checkbox"/> | Incontinency or dribbling | <input type="checkbox"/> |
| Change in urinary pattern | <input type="checkbox"/> | Sexual dysfunction        | <input type="checkbox"/> |
| History of STD's          | <input type="checkbox"/> |                           |                          |

**Personal/Social History:**

- Occupation \_\_\_\_\_
- |                        |     |           |                             |
|------------------------|-----|-----------|-----------------------------|
| Do you smoke now?      | Y N | How much? | _____ ppd for _____ years   |
| Smoked in the past?    | Y N | How much? | _____ ppd for _____ years   |
| Do you drink Alcohol?  | Y N | How much? | _____ day _____ wk _____ mo |
| Do you drink Caffeine? | Y N | How much? | _____ day _____ wk _____ mo |
| Do you Exercise?       | Y N | How much? | _____ day _____ wk _____ mo |
| Do you use a seatbelt? | Y N |           |                             |
- Other concerns: \_\_\_\_\_

**Prior Surgical History: please list all prior surgeries by year**

**List all Medications you are allergic to:**

Med \_\_\_\_\_ Reaction \_\_\_\_\_ Med \_\_\_\_\_ Reaction \_\_\_\_\_

**Current Medications you are taking:**

Name _____	Dose _____	Times/Day _____
Name _____	Dose _____	Times/Day _____
Name _____	Dose _____	Times/Day _____
Name _____	Dose _____	Times/Day _____
Name _____	Dose _____	Times/Day _____
Name _____	Dose _____	Times/Day _____
Name _____	Dose _____	Times/Day _____

**Please list the year you last had the following test, vaccine, or injection:**

Flu vaccine _____	Hepatitis vaccine _____	Shingles vaccine _____
Tetanus inj. _____	Pneumonia inj. _____	T.B. test _____
Rectal exam _____	Stool blood test _____	Colonoscopy _____
Eye exam _____	Dental exam _____	

**Family Medical History: please check all that apply:**

	Father	Mother	Children	Siblings
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Age at death _____	
Father	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Age at death _____	
Sibling	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Age at death _____	
Other	_____			

**Patient Signature:** \_\_\_\_\_ **Physician Signature:** \_\_\_\_\_