CENTRAL OHIO℠
PRIMARY CARE

Adult Comprehensive Patient History

☐ New Patient ☐ Established Patient

Name:_____D.O.B_____ Age:_____ Date:_____

Past History: *Check all that apply*

- ☐ Acid reflux
- ☐ Alcohol or Drug problems
- ☐ Allergy problems
- ☐ Anemia
- ☐ Artery problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ Cancer
- ☐ Colitis
- ☐ Crohn's disease
- ☐ Depression, Anxiety
- ☐ Diabetes
- ☐ Emphysema
  - ☐ Other lung disease
- ☐ Esophagitis, ulcers
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart disease
- ☐ Heart valve problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Recurrent skin infections
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sexually transmitted infections
- ☐ Stroke
- ☐ Thyroid diseases
- ☐ Vein problems
- ☐ Other diseases not listed _____
- ☐ Explain any of the above if necessary _____

_____

_____

- ☐ Hospitalizations _____

_____

Surgery/Procedures: (*check all that apply)*

- ☐ Appendix
- ☐ Bladder suspension
- ☐ Blood vessel surgery
  - ☐ Arteries
  - ☐ Veins
- ☐ Dental surgery
- ☐ Eye surgery
- ☐ Gallbladder
- ☐ Heart surgery
  - ☐ Bypass
  - ☐ Heart valve surgery
  - ☐ Angioplasty (balloon)
  - ☐ Stents
- ☐ Hysterectomy
  - ☐ Complete
  - ☐ Partial (ovaries preserved)
- ☐ Joint Replacement
- ☐ Orthopedic surgery
- ☐ Prostate surgery
- ☐ Tonsils and/or adenoids
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Other surgery not listed above _____
- ☐ Significant injuries _____

Medication List:

Name of medication, vitamin, OTC supplements or herbal medicine	Dosage	Supplies	Times/day	Disease or Reason

Medication allergies or reactions:

Medication	Reaction	Medication	Reaction
1		2	
3		4	

Name:_____

Family History:

Family Member	Date(s) of Birth	Living	Deceased	Diseases
Father				
Mother				
Brother(s) #				
Sisters(s) #				

Diseases in the family: Check all that apply

☐ Arthritis ☐ Addiction problems ☐ Bleeding Problems

Cancer(s) ☐ Colon ☐ Breast ☐ Prostate ☐ Other type of cancer(s) _____

☐ Depression/Anxiety ☐ Diabetes ☐ Heart disease ☐ High blood pressure

☐ High cholesterol ☐ Kidney disease ☐ Liver disease ☐ Mental illness

☐ Other

☐ Details / Other _____

_____

Social History:

Married? ☐ NO ☐ YES Divorced? ☐ NO ☐ YES Children? ☐ NO ☐ YES If yes, number of children _____

Family members living in the home: ☐ Mother ☐ Father ☐ Siblings ☐ Others: _____

Do you smoke? ☐ Currently ☐ Past ☐ Never _____ packs/day for _____ years. Other tobacco use? ☐ NO ☐ YES

If you do smoke, would you like information about our smoking cessation program? ☐ NO ☐ YES

Do you drink alcohol? ☐ NO ☐ YES ☐ Beer ☐ Wine ☐ Liquor. How many drinks per week? _____

How many servings of caffeine per day? _____ ☐ Coffee ☐ Tea ☐ Sodas

Do you limit salt in your diet? ☐ NO ☐ YES Do you limit fat? ☐ NO ☐ YES

Any illegal drug use? ☐ NO ☐ YES Type _____

Occupation _____Any known occupational exposures? _____

Do you exercise regularly? ☐ Yes ☐ No If so, how many times per week? _____ Type of exercise _____

Do you feel safe in your home? ☐ NO ☐ YES

Sexual Orientation? ☐ Not Applicable ☐ Heterosexual ☐ Homosexual

Preventative Care:

Date of last Colon and Rectal Cancer screening: _____ ☐ Rectal exam ☐ Sigmoidoscopy ☐ Colonoscopy

Date of last eye exam: _____ Have you had bone density (DEXA) exam? ☐ NO ☐ YES Date: _____

Do you use your seat belt? ☐ Yes ☐ No

Immunizations:	Date	**Immunizations:**	Date
Tetanus		Hepatitis A	
Influenza		Hepatitis B	
Pneumonia		Shingles	
Whooping cough		HPV	

For our FEMALE patients only:

Do you have a Gynecologist? ☐ Yes ☐ No If yes, Gynecologist name: _____

Date of last PAP test _____ Date of last mammogram _____ Do you do self-breast exams? ☐ Yes ☐ No

Have you gone through menopause? ☐ Yes ☐ No

Menstrual or period problems: ☐ Irregular ☐ Heavy ☐ Change in frequency _____

Number of pregnancies _____ Number of live births ____Vaginal ____ C-section ____ Miscarriages ____ # of abortions _____

Can you think of anything else that you think we should know about your health and lifestyle that is not listed here?

_____

For our MALE patients only: Date of last PSA test _____ Date of last rectal exam_____

Name:_____

Review of Systems:

Please indicate any problems in the following areas that are bothering you. If your planned visit is for a Preventative Physical, please be aware that another office visit may need to be scheduled to address new specific issues in appropriate detail.

Check all that apply:					
Constitutional:	☐ Fever	☐ Chills/Sweats	☐ Weight gain / Loss	☐ Fatigue	☐ Weakness
	☐ Poor appetite	☐ Appetite change			
Eyes:	☐ Blurred vision	☐ Double vision	☐ Eye pain		
Ears:	☐ Ear pain	☐ Decreased hearing	☐ Dizziness (light headed, room spinning)	☐ Ringing	
Nose:	☐ Congestion	☐ Sinusitis	☐ Difficulty breathing through nose	☐ Frequent nose bleeds	
Throat:	☐ Sore throat	☐ Sensation of fullness	☐ Difficulty swallowing		
Neck:	☐ Neck pain	☐ Fullness or lumps			
Cardiovascular:	☐ Chest discomfort (pain, pressure, fullness squeezing) with exertion or exercise			☐ Heart palpitations	
	☐ Heart racing	☐ Shortness of breath while lying down or with exertion (out of proportion to activity)			
	☐ Swelling of legs	☐ Fainting			
Pulmonary:	☐ Cough	☐ Emphysema (COPD)	☐ Shortness of Breath	☐ Asthma	
GI:	☐ Nausea	☐ Vomiting	☐ Abdominal pain		
	☐ Heartburn	☐ Sudden fullness	☐ Hemorrhoids		
	☐ Diarrhea	☐ Constipation	☐ Blood in stool	☐ Change in frequency of stools	
Genitourinary:	☐ Pain with urination	☐ Increased frequency of urination		☐ Frequent nighttime urination	
	☐ Blood in urine	☐ Sexual problems	☐ Difficulty with erections	☐ Vaginal pain	
	☐ Vaginal discharge	☐ Slow stream/dribbling	☐ Incontinence		
Musculoskeletal:	☐ Joint pains	☐ Muscle weakness	☐ Muscle pain	☐ Back pain	
Skin:	☐ Rash	☐ Sores	☐ Moles that are changing	☐ Itching	☐ Dry skin
	☐ Eczema	☐ Have seen dermatologist in past year	Dermatologist's name: _____		
Neurological:	☐ Headaches	☐ Numbness/Tingling	☐ Weakness	☐ Speech abnormalities	
	☐ Fainting	☐ Memory Problems	☐ Imbalance/vertigo	☐ Headaches	☐ Tremors
Psychological:	☐ Anxiety	☐ Eating disorder	☐ Obsessive behavior	☐ Depression	☐ Unusual fears
	☐ Mood swings	☐ Crying spells	☐ Lack of motivation	☐ Drug dependence	
	☐ Alcohol problems	☐ Insomnia	☐ Panic attacks	☐ Anger/Rage	

In the last 2 weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ NO

In the last 2 weeks, have you felt little interest or pleasure in doing things? ☐ Yes ☐ NO

Do you have Advanced Directives (Living Will, Durable Medical Power of Attorney)? ☐ Yes ☐ NO

Reviewed with patient on _____ Signature _____