CENTRAL OHIO PRIMARY CARE
FAMILY PRACTICE CENTER OF WESTERVILLE
190-A South State Street • Westerville, Ohio 43081-2200 • www.fpcw.net • (614) 882-2349 • Fax 614-882-9005
CAROL C. HOSTETTER, D.O. • ANN H. CALLAND, D.O. • ANDREW P. EILERMAN, D.O.

Name:__________________________ Age:______ DOB:_____/_____/_____ Date:_____/_____/_____

Past Medical History: (Please list the medical problems you have been diagnosed with.)

1.) ______ 5.) ______ 9.) ______
2.) ______ 6.) ______ 10.) ______
3.) ______ 7.) ______ 11.) ______
4.) ______ 8.) ______ 12.) ______

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	How Taken	Drug Name	Dose	How Taken	Drug Name	Dose	How Taken

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES? ❑ No ❑ Yes If yes, please explain.

______ ______ ______
______ ______ ______

Please List and Supply the Dates of:

Operations ______ ______ ______
______ ______ ______

Hospitalizations other than for surgery ______ ______
______ ______ ______

Immunization history—have you had:
Hepatitis B? ❑ No ❑ Yes When? ______
Pneumonia immunization? ❑ No ❑ Yes When? ______
Flu immunization? ❑ No ❑ Yes When? ______
Tetanus immunization? ❑ No ❑ Yes When? ______

When was your last:
Pap Smear? ______ Breast Exam? ______ Colon Cancer Test? ______
Mammogram? ______ Cholesterol check? ______ Prostate exam? ______

Social History:

Do you exercise regularly? ❑ No ❑ Yes If yes, how often? ______
Do you use illegal drugs? ❑ No ❑ Yes ______
Have you ever used nicotine? ❑ No ❑ Yes If yes, how many packs per week? ______ Quit in ______
Do you drink alcohol? ❑ No ❑ Yes If yes, how much per week? ______
Do you drink caffeine? ❑ No ❑ Yes If yes, what type (coffee, tea, soda) & how many cups per week? ______

Family History: Has any member of your family (including parents, grandparents, and siblings) ever had or been diagnosed with any of the following?

	Which family members?	*Age when diagnosed*
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart Disease		
Diabetes		
Strokes or TIA		
Mental disease (anxiety, depression)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other		

This information is for use by your physician as part of your confidential medical record.

MEDICAL HISTORY

Please continue on the next page

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Name:____ Date:_____/_____/____

Review of Systems

Please check off ☑ if you are presently or recently experiencing any of the following:

❑ High Blood Pressure	❑ Pneumonia	❑ Unexplained weight gain/loss	❑ Blood Disorders
❑ Diabetes	❑ Persistent Cough	❑ Hemorrhoids	❑ Irregular Vaginal Bleeding
❑ Cancer ____________	❑ Tuberculosis	❑ Gall Bladder Disease	❑ Sexually Transmitted Disease
❑ Heart Disease	❑ Hay Fever	❑ Colitis	❑ Anxiety
❑ Chest pain/chest tightness	❑ Abdominal Discomfort	❑ Hepatitis or jaundice	❑ Depression
❑ Shortness of breath	❑ Indigestion	❑ Thyroid Disease	❑ Anemia
❑ Swollen ankles	❑ Nausea	❑ Headaches	❑ Alcohol Abuse
❑ Palpitations	❑ Vomiting	❑ Kidney Disease	❑ Drug Abuse
❑ Light headedness	❑ Constipation	❑ Kidney Stones	❑ Gout
❑ Frequent urination	❑ Diarrhea	❑ Difficulty Urinating	❑ Impotence or Erectile Dysfunction
❑ Rheumatic Fever	❑ Blood in stool	❑ Arthritis	❑ Other: ______________________
❑ Asthma	❑ Ulcers	❑ Low Back Problems	______________________________
❑ Bronchitis	❑ Change in bowel habits	❑ Skin Disease	______________________________

Gynecologic and Obstetric History

Age at onset of periods __________________ Frequency __________________ Length of period __________________

Pregnancies ____________________________ Births ______________________ Miscarriages __________________

Prolonged or abnormal bleeding ❑ No ❑ Yes (Please describe) ________________________

Leakage of urine ❑ No ❑ Yes (Please describe) ________________________

Pelvic pain ❑ No ❑ Yes (Please describe) ________________________

Abnormal discharge ❑ No ❑ Yes (Please describe) ________________________

History of abnormal Pap smear ❑ No ❑ Yes (Please describe) ________________________

Method of birth control? ____

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Reviewed by:___________________________

Date:_____/_____/____

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MEDICAL HISTORY