

P# _____

**CENTRAL OHIO PRIMARY CARE
FAMILY PRACTICE CENTER OF WESTERVILLE**

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CAROL C. HOSTETTER, D.O. • ANN H. CALLAND, D.O. • ANDREW P. EILERMAN, D.O.

Dr# _____

PATIENT HEALTH HISTORY – ADULT

PATIENT NAME: _____ DOB: _____ Today's Date: _____

MEDICATION HISTORY: Please list all medications, supplements or OTC you are presently taking:

ALLERGY HISTORY: Please list ALL allergies to medications, x-ray dyes, foods or other substances NO allergies to medications or foods

FAMILY HISTORY Has any member of your immediate family (including parents, grandparents or siblings) ever had or been diagnosed with any of the following?		IMMUNIZATION HISTORY When was your last:
DISEASE CONDITION	FAMILY MEMBER & AGE WHEN DIAGNOSED	Tetanus Shot?
Cancer(s)		Flu Shot?
High Blood Pressure		Pneumonia Shot?
Heart Disease		Shingles Vaccine?
Diabetes		Hepatitis B Series?
Strokes or Tia's		OTHER:
Mental Disease (Anxiety or Depression)		
Drug Addiction		
Alcohol Addiction		
Glaucoma		
Bleeding Disorders		
OTHER:		

SOCIAL HISTORY & HABITS

Do you exercise regularly? N Y How many times per week? _____

Have you ever used nicotine? N Y How many packs per week? _____ Quit in: _____

Do you drink alcohol? N Y How many drinks per week? _____

Do you drink caffeinated beverages? N Y How many per day? _____

Do you have a living will? N Y Do you have a donor card? N Y

What type of diet do you follow? _____

Marital Status M S D W Partner His/Her Name: _____

Your Occupation _____ Employer _____

PAST MEDICAL HISTORY ✓ (Check all that you have been diagnosed with)

Alcoholism	Epilepsy	Liver /Hepatitis(s)	Sore Throats - Chronic
Anemia	Eye Disease	Lung Disease/Asthma	Strokes/Tia's
Angina	Hearing Loss/Problems	Mental Problems	Ulcers
Arthritis	Heart Disease	Migraines	OTHER:
Cancer(s)	High Blood Pressure	Recent Weight Loss/Gain	
Diabetes	High Cholesterol	Reflux/Stomach Issues	
Drug Addiction	Kidney/Bladder Problems	Sinus Problems	

SURGICAL HISTORY Please list any surgical procedures or hospitalizations you have had: Procedure _____ Doctor _____ Year _____	WELLNESS HISTORY When was your last: Mammogram? _____ Pap? _____ Eye Exam? _____ Bone Density? _____ Last Physical? _____ Last EKG? _____ Last PSA? _____ Last Colonoscopy? _____
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Reviewed by: _____