

P# _____

**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.

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?

| DISEASE CONDITION | FAMILY MEMBER & AGE WHEN DIAGNOSED |
|--|------------------------------------|
| Cancer(s) | |
| High Blood Pressure | |
| Heart Disease | |
| Diabetes | |
| Strokes or Tia's | |
| Mental Disease (Anxiety or Depression) | |
| Drug Addiction | |
| Alcohol Addiction | |
| Glaucoma | |
| Bleeding Disorders | |
| OTHER: | |

IMMUNIZATION HISTORY

When was your last:

- Tetanus Shot? _____
- Flu Shot? _____
- Pneumonia Shot? _____
- Shingles Vaccine? _____
- Hepatitis B Series? _____
- 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? _____

Reviewed by: _____