COLUMBUS ADULT MEDICINE RETURN EXAM

Appointment Date_____

Name_____ Preferred Name_____ Birth date_____

Preferred Pharmacy _____

What concerns do you have that you would like us to address today?

New **medical problems** or **surgeries**: ❑No ❑Yes (describe)

MEDICATIONS—List all regularly used prescription and non-prescription drugs, vitamins, and herbs
❑ I have a separate list of medications I will show you. ❑ I take no medications or supplements routinely.
❑ I have been seen in the office in the past 4 months and there are no changes in my medications.

Drug / Dose / How often taken	Need Refill	Drug / Dose / How often taken	Need Refill

New **ALLERGIES** to medications: ❑No ❑Yes (what)

SOCIAL HISTORY/HABITS/SAFETY
Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Yes No
❑ ❑ Tobacco use? # packs/day_____
Age started smoking_____
❑ ❑ Prior tobacco use? Year quit_____
Number of years smoked_____
Average # packs/day_____
❑ ❑ Drink alcohol regularly? # drinks/day____
 Wine Beer Liquor
❑ ❑ Exercise regularly (at least 3x/week)
❑ ❑ Eat a healthy, balanced diet
Particular type diet_____
❑ ❑ Caffeinated drinks? #drinks/day_____
❑ Coffee ❑ Soda ❑ Tea

Yes No
❑ ❑ Salt intake? ____none ____minimal
____significant ____excessive
❑ ❑ High fiber intake?
❑ ❑ Calcium supplement_____mg
❑ ❑ Always wear your seatbelt
❑ ❑ Contact with blood or body fluid at work
❑ ❑ Use skin protection with sun exposure
❑ ❑ Regular dental exams
❑ ❑ Regular eye exams

Occupation (if changed):

New Family medical problems since last annual exam: ❑No ❑Yes (describe)

REVIEW OF SYSTEMS

Please check any of the following problems that you may have. If no problems in a category, check "none".

GENERAL ❑None
- ❑ Fever/chills
- ❑ Loss of interest in eating
- ❑ Weight loss 10+ pounds
- ❑ Weight gain 10+ pounds
- ❑ Fatigue ❑ Tiredness
- ❑ Other_____

HEAD ❑None
- ❑ Headaches

EYES ❑None
- ❑ Blurred vision
- ❑ Double vision
- ❑ Loss of vision
- Cared for by_____

EARS ❑None
- ❑ Frequent ear aches/infections
- ❑ Hearing difficulties
- ❑ Ringing/buzzing in ear
- ❑ Vertigo/motion sickness

NOSE ❑None
- ❑ Allergies
- ❑ Frequent nose bleeds
- ❑ Sinus congestion
- ❑ Sinus drainage
- ❑ Other _____

THROAT/MOUTH ❑None
- ❑ Dental problems
- ❑ Hoarseness/voice changes
- ❑ Mouth sores
- ❑ Sore throat
- ❑ Swellings of gums or jaw
- ❑ Other _____

Neck ❑None
- ❑ Neck pain
- ❑ Neck lumps
- ❑ Enlarged thyroid/goiter
- ❑ Other _____

LUNGS ❑None
- ❑ Coughing up sputum
- ❑ Coughing up blood
- ❑ Excessive/frequent cough
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Other_____

CHEST WALL ❑None
- ❑ Chest wall tenderness

HEART ❑None
- ❑ Chest pain
- ❑ Palpitations
- ❑ Other_____

BREAST ❑None
- ❑ Breast lump/mass
- ❑ Breast tenderness
- ❑ Nipple discharge
- ❑ Other_____

DIGESTIVE/INTESTINAL ❑None
- ❑ Abdominal pain
- ❑ Belching ❑ Bloating
- ❑ Difficulty swallowing
- ❑ Heartburn ❑ Indigestion
- ❑ Nausea ❑Vomiting
- ❑ Diarrhea ❑ Constipation
- ❑ Blood in stool
- ❑ Other_____

GENITOURINARY ❑None
- ❑ Burning with urination
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Frequent urine infections
- ❑ Leak urine with cough/sneeze
- ❑ Leak urine with urgency
- ❑ Leak urine with cough/sneeze
- ❑ Urination at night

How often? _____

FOR MEN ONLY ❑None
- ❑ Erectile difficulties

FOR WOMEN ONLY ❑None
- ❑ Change in periods
- ❑ Hot flashes
- ❑ Vaginal dryness
- ❑ Other_____

Cared for by_____

BACK ❑None
- ❑ Back pain
- ❑

Other_____

MUSCOLOSKELETAL ❑None
- ❑ Joint pain ❑ Joint swelling
- ❑ Muscle pains
- ❑ Leg pain while walking
- ❑ Other_____

EXTREMITIES ❑None
- ❑ Fluid retention
- ❑ Swelling of legs

NEUROLOGICAL ❑None
- ❑ Difficulty in walking
- ❑ Dizziness
- ❑ Lightheadedness
- ❑ Fainting
- ❑ Memory loss
- ❑ Numbness/tingling sensations
- ❑ Seizures
- ❑ Tremors/hands shaking
- ❑ Weakness
- ❑ Other_____

MOOD ❑None
- ❑ Anxious or ❑ nervous
- ❑ Sad, down, depressed
- ❑ Lack of interest in activities
- ❑ Difficulty concentrating
- ❑ Sleep too much or ❑ too little
- ❑ Irritable, moody, cry easily
- ❑ Suicidal thoughts
- ❑ Decrease in sexual desire
- ❑ Other_____

ENDOCRINE ❑None
- ❑ Night sweats
- ❑ Heat or ❑ cold intolerance
- ❑ Excessive hair growth or ❑loss
- ❑ Abnormal thirst
- ❑ Other_____

BLOOD/LYMPH ❑None
- ❑ Anemia (or history of)
- ❑ Bruising or ❑ bleeding easily
- ❑ Enlarged lymph nodes
- ❑ Other_____

SKIN ❑None
- ❑ Dry skin
- ❑ Itching
- ❑ Previous skin cancer
- ❑ Rash
- ❑ Unusual or change in moles
- ❑ Other_____

ALLERGIES ❑None
- ❑ Asthma
- ❑ Environmental allergies
- ❑ Hives

Thank you for taking the time to fill out the above information.