

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.