



3203 Middle Road, Columbus, IN 47203
Telephone: 812-373-2700

Electronic Medical Record History — Male

Patient Name: _____ DOB: _____
Date: _____

Drug Allergies

Product Name _____ Reaction _____
Product Name _____ Reaction _____

Allergies Other

Are you allergic to:

Iodine Yes No
Latex Yes No
Food Yes No
Chemical Yes No
Anesthetic Yes No
Other Yes No

Further Information

Past History

Have you had:

If so, please describe:

Infection History _____
Past Illnesses _____
Chronic Diseases _____
Accidents _____

Surgical Operations

Type of Surgery	Date of Surgery	Reason for Surgery	Name of Surgeon	Name of Facility

Hospitalizations

1. Hospital Name and Location _____ Date Admitted _____
Reason for Admission _____
2. Hospital Name and Location _____ Date Admitted _____
Reason for Admission _____

Patient Name: _____ DOB: _____

FAMILY HISTORY

FAMILY MEMBER	AGE	HISTORY

SOCIAL HISTORY

Alcohol Use	Seat Belt Use
Smoking	Sexual Activity
Diet	Residence
Lifestyle/Recent Changes	Place of Birth
Exercise	Job Description
Education	Hours Worked
Occupation	Spouse's Occupation
Street Drug Use	Off The Record

Review of Systems — List any problems

General	
Skin	
Eyes	
Ears	
Nose	
Mouth/Throat	
Neck	
Lungs	
Breast	
Heart	
Gastrointestinal	
Urinary	
Musculoskeletal	
Neurological	
Endocrine	
Blood	
Psychiatric	

Patient Name: _____ DOB: _____

Health Maintenance History

CLINICAL INFORMATION	DATE OF TEST / PROCEDURE	NOTES
Pneumovax		
TB Test		
Tetanus Vaccine		
Chemistry Panel		
Chest X-Ray		
Cholesterol Test		
Colonoscopy		
Dexa Scan		
Digital Rectal Exam		
Dilated Fundus Exam		
Eye Exam		
ECG (Baseline)		
Hearing Test		
Male Testicular Exam		
Pulmonary Function Test		
Physical Exam		
PSA Blood Test		
Seat Belts		
Stool Occult Blood Test		
Stop Smoking		
Urinalysis		