OhioHealth Gastroenterology Physicians
5131 Beacon Hill Road, Suite 200
Columbus, OH 43224

Patient Medical History Form

Date of Visit: _____

Patient Name: _____ **Date of Birth:** _____

Occupation: _____ **Marital Status:** _____

Education: _____

Primary Care Physician: _____
Name Address City/Zip

Referring Physician: _____
Name Address City/Zip

Other Physician: _____
Name Address City/Zip

Reason for Visit: _____

Current Medication including over the counter medication and herbal medication:

Name	Dose	Frequency	Name	Dose	Frequency

Drug Allergies: _____

Previous Surgeries (or procedures)

Endoscopy	Year	Endoscopy	Year
Surgery	Year	Surgery	Year
Surgery	Year	Surgery	Year

Smoke: Yes ____No ____ PPD _____Years _____Quit _____Cigars _____Chew _____ Pipe ____

Alcohol: Yes ____No ____ 1 oz/day _____ 2 oz/day ____ 3 oz/day _____ 4 oz/day ____ more _____

Beer: Yes ____No ____ 1/day _____ 2/day _____ more than 4/day _____

Coffee: Yes____No____ more than 2 cups/day _____

Name _____ **Date of Visit** _____

Your Medical History (circle)	**Family History** (circle and list who is in immediate family) Mom, Dad, Brothers, Sisters, your children	**These Apply to Me Now** (circle)
Anemia	anemia _____	fever / sweats / chills
Blood transfusion	arthritis _____	weight loss / gain
Cancer: _____	Thyroid disease _____	fatigue / weakness
Chemo / radiation therapy	diabetes _____	fainting episodes
Thyroid	high blood pressure _____	heat / cold intolerance
Diabetes	stroke _____	stress / anxiety / depression
Arthritis	heart disease _____	rashes / itching / lesions /lumps
Seizures	gallbladder disease _____	eye redness / irritation
Psychiatric	stomach ulcers _____	neck pain
Asthma	irritable bowel syndrome ____	mouth sores
Emphysema	liver disease _____	cough / wheezing / hoarseness
Elevated cholesterol	pancreas disease _____	shortness of breath
High blood pressure	colitis _____	chest pain / palpitations
Stroke / TIA	colon polyps _____	nausea / vomiting
Blood clots	colon cancer _____	heartburn
Heart attack / congestive heart failure	cardiovascular disease _____	difficulty swallowing
Abnormal rhythm (heart) / valve disorder	other (list) _____	food intolerance
Kidney stones	_____	bloating / flatus (gas)
GERD / reflux	_____	excessive belching
Ulcers		abdominal pain
Gallbladder stones / dysfunction		regurgitation
Liver disease		loss of appetite
Immunized: Hep A ___ Hep B _____	**OFFICE USE ONLY**	jaundice (yellow skin / eyes)
Pancreatitis		light-colored / black / red stool
Irritable bowel syndrome	Ht. _____	constipation
Crohn's disease		laxative use
Ulcerative colitis	Wt. _____	rectal bleeding
Celiac sprue		incontinence of stool
Polyps: where _____	BP. _____	diarrhea
Diverticulosis		back pain / leg pain / joint pain
Hemorrhoids	P _____	swelling of feet and hands
Sexually transmitted disease: type _____		incontinence of urine
Other (list)	R _____	difficulty starting stream
_____		painful urination
_____	T _____	change in color of urine(tea /brown)
_____		blood in urine
		other (list)
		_____
		_____

Practioner Notes

_____
_____
_____
_____
_____
_____
_____
_____
_____

Practioner Signature _____ Date _____