

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)

_____	Year	_____	Year
Endoscopy		Endoscopy	
_____	Year	_____	Year
Surgery		Surgery	
_____	Year	_____	Year
Surgery		Surgery	

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
 Blood transfusion
 Cancer: _____
 Chemo / radiation therapy
 Thyroid
 Diabetes
 Arthritis
 Seizures
 Psychiatric
 Asthma
 Emphysema
 Elevated cholesterol
 High blood pressure
 Stroke / TIA
 Blood clots
 Heart attack / congestive heart failure
 Abnormal rhythm (heart) / valve disorder
 Kidney stones
 GERD / reflux
 Ulcers
 Gallbladder stones / dysfunction
 Liver disease
 Immunized: Hep A ___ Hep B ___
 Pancreatitis
 Irritable bowel syndrome
 Crohn's disease
 Ulcerative colitis
 Celiac sprue
 Polyps: where _____
 Diverticulosis
 Hemorrhoids
 Sexually transmitted disease: type _____
 Other (list)

anemia _____
 arthritis _____
 Thyroid disease _____
 diabetes _____
 high blood pressure _____
 stroke _____
 heart disease _____
 gallbladder disease _____
 stomach ulcers _____
 irritable bowel syndrome _____
 liver disease _____
 pancreas disease _____
 colitis _____
 colon polyps _____
 colon cancer _____
 cardiovascular disease _____
 other (list) _____

fever / sweats / chills
 weight loss / gain
 fatigue / weakness
 fainting episodes
 heat / cold intolerance
 stress / anxiety / depression
 rashes / itching / lesions /lumps
 eye redness / irritation
 neck pain
 mouth sores
 cough / wheezing / hoarseness
 shortness of breath
 chest pain / palpitations
 nausea / vomiting
 heartburn
 difficulty swallowing
 food intolerance
 bloating / flatus (gas)
 excessive belching
 abdominal pain
 regurgitation
 loss of appetite
 jaundice (yellow skin / eyes)
 light-colored / black / red stool
 constipation
 laxative use
 rectal bleeding
 incontinence of stool
 diarrhea
 back pain / leg pain / joint pain
 swelling of feet and hands
 incontinence of urine
 difficulty starting stream
 painful urination
 change in color of urine(tea /brown)
 blood in urine
 other (list)

OFFICE USE ONLY

Ht. _____
 Wt. _____
 BP. _____
 P _____
 R _____
 T _____

Practioner Notes

Practioner Signature _____

Date _____