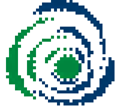

Northwest Ohio Gastroenterology Associates
Northwest Ohio Endoscopy Center

PATIENT HISTORY QUESTIONNAIRE

Name: ____

Date of Birth: __________________________________

Medical Illness/Surgery
List all types of illness and surgeries, past and present, including dates.

____
____
____
____
____
____
____
____
____
____

Medications
List all prescription or over-the-counter medications, birth control pills, vitamins, and herbs.

Medication	Strength	How Often

Medication Allergies
List all medications that you are allergic to:

____
____

Food Allergies/Intolerances:

____

Reviewed with the patient:
Date: _________________
Dr. Signature: __________________________________

PLEASE COMPLETE BOTH SIDES

Date: ______________________

Patient Social History

Marital Status:
___Single ___Married ___Separated
___Divorced ___Widowed

Use of Alcohol:
___Never ___Rarely ___Moderate
How much: ______How often: __________
Any heavy drinking in the past? _________

Use of Tobacco:
___Never ___Present: How much? ____
___Previously but quit When? _________

Use of illicit drugs:
___Never
___Type and Frequency: _______________

Family Medical History (especially stomach, colon, and liver diseases)

Relative	Age	Disease	If deceased, cause of death
Father			
Mother			
Sibling			
Sibling			
Sibling			
Spouse			
Child			
Child			

Have you ever had an endoscopy or colonoscopy? If yes, where, by whom, and what were the findings?

____
____
____

	YES	NO
Constitutional Symptoms:		
Chronic Fatigue	____	____
Recent weight loss/gain	____	____
Fever, recurrent	____	____
Eyes		
Eye disease or injury	____	____
Wear glasses/contacts	____	____
Blurred/double vision	____	____
Glaucoma	____	____
Eye Infection	____	____
Failing vision	____	____
Ears, Nose, Mouth, Throat		
Hearing loss or tingling	____	____
Ear infections/drainage	____	____
Chronic sinus problems	____	____
Nose bleeds	____	____
Mouth sores	____	____
Bleeding gums	____	____
Bad breath/taste	____	____
Hoarseness	____	____
Swollen glands in neck	____	____
Cardiovascular		
Heart trouble	____	____
Chest Pain	____	____
Heart attack	____	____
Palpitations	____	____
Shortness of breath—walking	____	____
Shortness of breath—lying	____	____
Swelling of feet, ankles or hands	____	____
Rheumatic fever	____	____
Heart valve disease	____	____
High blood pressure	____	____
Respiratory		
Chronic or frequent cough	____	____
Spitting up blood	____	____
Shortness of breath	____	____
Asthma or wheezing	____	____
Bronchitis	____	____
Tuberculosis	____	____
Emphysema	____	____
Gastrointestinal		
Loss of appetite	____	____
Change in bowel movements	____	____
Nausea or vomiting	____	____
Frequent diarrhea	____	____
Constipation	____	____
Rectal bleeding	____	____
Blood in stool	____	____
Abdominal pain	____	____
Heartburn	____	____
Peptic ulcer	____	____
Hiatal hernia	____	____
Yellow jaundice	____	____
Hepatitis	____	____
Cirrhosis	____	____
Pancreatitis	____	____
Hemorrhoids	____	____

	YES	NO
Genitourinary		
Frequent urination	____	____
Burning or painful urination	____	____
Blood in urine	____	____
Change in force/flow of urine	____	____
Kidney stones	____	____
Sexually transmitted disease	____	____
Prostate disease	____	____
Menstrual problems	____	____
Musculoskeletal		
Joint pain	____	____
Joint stiffness or swelling	____	____
Weakness of muscles or joints	____	____
Muscle pain or cramps	____	____
Back pain	____	____
Cold extremities	____	____
Difficulty in walking	____	____
Multiple sclerosis	____	____
Muscular dystrophy	____	____
Arthritis	____	____
Skin		
Rash or itching	____	____
Change in skin color	____	____
Change in hair or nails	____	____
Hives	____	____
Psychiatric		
Memory loss or confusion	____	____
Nervousness	____	____
Depression	____	____
Neurological		
Frequent/recurring headaches	____	____
Migraines	____	____
Light-headed or dizzy	____	____
Convulsions or seizures	____	____
Numbness or tingling sensations	____	____
Tremors	____	____
Paralysis	____	____
Stroke	____	____
Head injury	____	____
Sleep apnea	____	____
Endocrine		
Glandular or hormone problems	____	____
Thyroid disease	____	____
Diabetes	____	____
Excessive thirst or urination	____	____
Hematological/Lymphatic		
Slow to heal after cuts	____	____
Bleeding or bruising easily	____	____
Anemia	____	____
Phlebitis/blood clots	____	____
Past transfusions	____	____
Leukemia	____	____
Lymphoma	____	____
HIV/AIDS	____	____
Sickle cell	____	____