Digestive Medical Services, Inc.

Westerville Office	Columbus/Reynolsburg Office	Lancaster Office
477 Cooper Road, Suite 230 Westerville, Ohio 43081 (614) 834-9929 (614) 834-411 Fax	1418 Brice Road, Suite 201 Columbus, Ohio 43213 (614) 834-9929 (614) 834-4114 Fax	1548 Sheridan Dr. Lancaster, Ohio 43130 (740) 681-9575 (740) 681-9747 Fax

PATIENT INFORMATION

Patient Name: _________________________________ DOB:_____________________________

Address:_____________________________________ City:____________________

State:______________________ Zip code: __________Social security #:__________________________

Phone #:_____________________________________Marital Status: _______________________________

Patient 's Employer:___________________________Occupation__________________________________

Work Phone # :_________________________

Spouse Employer: _____________________________occupation__________________________________

Work Phone #: ____________________

Primary Care Doctor_____________________________________

Primary Care Physician Phone#:_____________________________

Referring Physician's Name :

____

Other Doctor involved with your care: ____

Why are you here to see the doctor?

I

INSURANCE INFORMATION

Primary Ins:______________________________

Group #_______________________________

ID #______________________________________

Policy Holder:__________________________

Address:

____

Secondary Ins.___________________________

Group# :_____________________________

ID# :_____________________________________

Policy Holder:________________________

Relationship to the patient:_____________________________

DOB:_________________________________

PERSONAL HISTORY – Have you had any of the following: Circle "yes" or "no"

Poor Appetite	**yes**	**no**	**Tarry Stools**	**yes**	**no**
Weight Loss	**yes**	**no**	**Dark Urine**	**yes**	**no**
Belching or excess gas	**yes**	**no**	**Rectal bleeding**	**yes**	**no**
Abdominal enlargement	**yes**	**no**	**Constipation**	**yes**	**no**
Nauseas	**yes**	**no**	**diarrhea**	**yes**	**no**
Vomiting	**yes**	**no**	**Abdominal pain**	**yes**	**no**
Vomiting of blood	**yes**	**no**	**Hemorrhoids**	**yes**	**no**
Peptic ulcers	**yes**	**no**	**Need for laxatives**	**yes**	**no**
Jaundice	**yes**	**no**			
Hepatitis	**yes**	**no**			

DRUG ALLERGIES

Penicillin	**yes**	**no**
MVP/Murmur	**yes**	**no**
Dye contrast	**yes**	**no**

Shellfish	**yes**	**no**
Eggs	**yes**	**no**
Any others:	**yes**	**no**

FAMILY HISTORY

Have you or any blood relative had any of the following :

Circle "yes "or "no"- if so, what relationship:

Anemias	**yes**	**no**	____
Bleeding tendency	**yes**	**no**	____
Heart diseases	**yes**	**no**	____
Chronic lung diseases	**yes**	**no**	____
Tuberculosis	**yes**	**no**	____
High blood pressure	**yes**	**no**	____
Asthma	**yes**	**no**	____
Severe allergies	**yes**	**no**	____
Convulsion or seizures	**yes**	**no**	____
Diabetes	**yes**	**no**	____
Thyroid disease	**yes**	**no**	____
Peptic ulcers	**yes**	**no**	____
Chronic diarrhea	**yes**	**no**	____
Cancer (type/relationship)	**yes**	**no**	____
Liver disease	**yes**	**no**	____
Childhood disease	**yes**	**no**	____

List surgeries and serious illness: ____