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Board-Certified in Gastroenterology

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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____

Email

Personal:_____

Race

Select one or more

- ◯ White
- ◯ Black or African American
- ◯ Asian
- ◯ American Indian or Alaska Native
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ Other Race
- ◯ Unknown
- ◯ Patient declines to specify
- ◯ Prohibited by state law

Ethnicity

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Patient declines to specify
- ◯ Prohibited by state law
- ◯ Unknown

Sex

- ◯ Male
- ◯ Female
- ◯ Other
- ◯ Unknown

Preferred Language

Contact Preference

- ◯ Portal
- ◯ No preference
- ◯ Patient declines to specify

Other:_____

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

- ◯ Yes
- ◯ No

Current Medications

☐ None

Name Dose How taken?

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

☐ Aspirin ☐ Codeine Sulfate ☐ Demerol ☐ Eggs ☐ Iodine-Iodine Containing

☐ latex gloves ☐ Penicillins ☐ Propofol/Diprivan ☐ Sulfa (Sulfonamide Antibiotics) ☐ Versed/midazolam

Other: Other:

Pharmacy

Name Address Phone

Immunizations

☐ None

☐ Hep A ☐ Hep B ☐ Pneumonia

When: When: When:

Diagnostic Studies/Tests

☐ None

☐ Bravo Capsule ☐ Capsule Endoscopy-Small Bowel ☐ Colonoscopy ☐ Endoscopy (EGD) ☐ Esophageal Manometry

When: When: When: When: When:

☐ Sigmoidoscopy

When:

Past or Present Medical Conditions

- ◯ None
- ◯ Alcoholic Liver
- ◯ Anemia
- ◯ Anxiety disorder
- ◯ Arthritis
- ◯ Asthma
- ◯ Atrial Fibrillation
- ◯ Barrett's Esophagus
- ◯ Bleeding disorder
- ◯ Breast cancer
- ◯ C-Diff Infection
- ◯ Celiac Sprue
- ◯ Cirrhosis
- ◯ Colon cancer
- ◯ Colon polyps
- ◯ C.O.P.D.
- ◯ Congestive Heart Failure
- ◯ Coronary Artery disease
- ◯ Crohn's Disease
- ◯ Dementia
- ◯ Depression
- ◯ Diabetes
- ◯ Diabetes-Insulin Dependent
- ◯ Diverticulitis
- ◯ Diverticulosis
- ◯ Emphysema
- ◯ Endometriosis
- ◯ Esophageal Cancer
- ◯ Esophageal Varices
- ◯ Fatty Liver
- ◯ Fibromyalgia
- ◯ Gallstones
- ◯ Gastric Ulcer
- ◯ Gastrointestinal (GI) Bleeding
- ◯ GERD
- ◯ Glaucoma
- ◯ Gynecologic Cancer
- ◯ H. Pylori
- ◯ Heart Attack
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ Hepatitis-Other
- ◯ High blood pressure
- ◯ High (elevated) cholesterol
- ◯ HIV
- ◯ Hyperthyroidism
- ◯ Hypothyroidism
- ◯ Irritable Bowel Syndrome (IBS)
- ◯ Ischemic Colitis
- ◯ Kidney disease
- ◯ Kidney Stones
- ◯ Leukemia
- ◯ Liver Cancer
- ◯ Liver disease
- ◯ Lung cancer
- ◯ Lymphoma
- ◯ Obesity
- ◯ Ovarian Cancer
- ◯ Pancreatitis
- ◯ Prostate Cancer
- ◯ Renal Failure
- ◯ Seizures
- ◯ Sleep apnea
- ◯ Stroke
- ◯ Ulcer Duodenal
- ◯ Ulcer Gastric
- ◯ Ulcerative Colitis

Other: _____

Previous Procedures

- ◯ None
- ◯ AICD (defibrillator)
- ◯ Appendectomy
- ◯ Blood Transfusions
- ◯ C-Section
- ◯ CABG/Heart Bypass
- ◯ Cardiac Surgery
- ◯ Cholecystectomy/Gallbladder
- ◯ Colon Polyp removed
- ◯ Colon Resection
- ◯ Colostomy
- ◯ ERCP
- ◯ Gastric By-Pass
- ◯ Gastroscopy
- ◯ Heart Valve Replacement
- ◯ Hiatal Hernia Repair
- ◯ Hysterectomy
- ◯ Ileostomy
- ◯ Joint Surgery/Replacement
- ◯ Kidney Dialysis
- ◯ Liver Biopsy
- ◯ Liver Transplant
- ◯ Mastectomy
- ◯ Metal Implants (any)
- ◯ Pacemaker
- ◯ Prostate Surgery
- ◯ Small Bowel Resection

Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Separated
- ◯ Widowed
- ◯ Other

Alcohol

- ◯ None
- ◯ Beer
- ◯ Wine
- ◯ Liquor

Caffeine

- ◯ None
- ◯ Coffee
- ◯ Tea

Tobacco

Smoking Status

- ◯ Current every day smoker
- ◯ Current some day smoker
- ◯ Former smoker
- ◯ Never smoker
- ◯ Smoker, current status unknown
- ◯ Light tobacco smoker
- ◯ Heavy tobacco smoker
- ◯ Unknown if ever smoked

Type	Started	Quit	Quantity
◯ Cigarettes			
◯ Chewing Tobacco			
◯ Pipe			
◯ Smokeless			

Drug Use

- ◯ None

Type	Quantity	Frequency

Exercise

None

Type

Frequency

Family Medical History

No knowledge of family history

No family history of Colon cancer Polyps

	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather
Health Status								
Alive								
Deceased/At Age								
Diagnoses								
Family Hx of Breast Cancer								
Family Hx of Colitis								
Family Hx of Colon Cancer								
Family Hx of Crohn's disease								
Family Hx of Esophageal Cancer								
Family Hx of Gastric Cancer								
Family Hx of Heart Problems								
Family Hx of Liver Disease								
Family Hx of Pancreatic Cancer								

Review Of Systems

Allergic/Immunologic

None	Y	N
allergies (environmental)	○	○
HIV exposure	○	○
immune deficiency	○	○
persistent infections	○	○
recurrent hives	○	○

Cardiovascular

None	Y	N
angina	○	○
chest pain	○	○
heart murmur	○	○
irregular heart beat	○	○
peripheral edema	○	○
rapid heart rate	○	○
shortness of breath (exertion)	○	○
shortness of breath (position)	○	○

Constitutional

None	Y	N
chills	○	○
fatigue	○	○
fever	○	○
loss of appetite	○	○
night sweats	○	○
weight gain	○	○
weight loss	○	○

ENMT

None	Y	N
double vision	○	○
loss of vision	○	○
difficulty swallowing	○	○
eye pain	○	○
eye redness	○	○
chronic sore throat	○	○
decreased hearing	○	○
recurrent ear infections	○	○
hoarseness	○	○
mouth sores	○	○
nose bleeds	○	○
post nasal drip	○	○
ringing in ears	○	○
recurrent sinus infections	○	○

Endocrine

None	Y	N
cold intolerance	○	○
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○
night time or frequent urination	○	○

Gastrointestinal

None	Y	N
abdominal pain (upper)	○	○
abdominal pain (lower)	○	○
abdominal swelling	○	○
black stools	○	○
bloating	○	○
change in bowel habits (frequency)	○	○
change in bowel habits (stool caliber)	○	○
constipation	○	○
diarrhea	○	○
gas (belching)	○	○
gas (flatulence)	○	○
heartburn	○	○
incontinence of stool	○	○
jaundice	○	○
loss of appetite	○	○
nausea	○	○
painful bowel movement	○	○
red blood in stool	○	○
swallowing trouble	○	○
vomiting	○	○

Genitourinary

None	Y	N
blood in urine	○	○
frequent urinary infections	○	○
frequent urination	○	○
pain on urination	○	○
sexually transmitted diseases	○	○
urinary incontinence	○	○

Hematologic/Lymphatic

None	Y	N
easy bruising	○	○
palpable/enlarged lymph glands	○	○
prolonged bleeding	○	○

Integumentary

None	Y	N
eczema	○	○
hives	○	○
itching	○	○
jaundice	○	○
rash	○	○
suspicious lesions	○	○

Musculoskeletal

None	Y	N
back pain	○	○
joint deformity	○	○
joint pain	○	○
joint swelling/redness	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

None	Y	N
dizziness	○	○
headaches	○	○
lightheadedness	○	○
memory loss/confusion	○	○
numbness/tingling	○	○
seizures	○	○
stroke	○	○
temporary paralysis	○	○
tremors	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations/paranoia	○	○
panic attacks	○	○
suicidal thoughts	○	○

Respiratory

None	Y	N
cessation (stopping) of breathing when asleep	○	○
coughing blood	○	○
excessive sputum	○	○
frequent cough	○	○
shortness of breath	○	○
snoring	○	○
wheezing	○	○

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

○ Yes ○ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

Yes No

Signature

Signature Date