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GASTROENTEROLOGY, P.A.
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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Email

Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Race

Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ 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

Sex

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ Patient declines to specify

Contact Preference

☐ Letter ☐ Email ☐ Cell phone ☐ Telephone call-Work ☐ Telephone call - Home

☐ Patient declines to specify Other:_____

Pharmacy

Name Address Phone

Allergies

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

Eggs Latex Peanuts

Current Medications

☐ None

Name	Dose	How taken?

Immunizations

☐ None

☐ Shingles
When:_____

☐ Pneumococcal conjugate PCV 13
When:_____

☐ Influenza, seasonal, injectable, preservative free
When:_____

Diagnostic Studies/Tests

☐ None

☐ EGD
When:_____

☐ Colonoscopy
When:_____

☐ ERCP
When:_____

☐ CT Abdomen/Pelvis
When:_____

☐ Abdominal Ultrasound
When:_____

☐ Capsule Endoscopy
When:_____

Past or Present Medical Conditions

☐ None

GI

☐ Crohn's Disease
When:_____

☐ Inflammatory bowel disease
When:_____

☐ Irritable bowel syndrome
When:_____

☐ Scleroderma
When:_____

☐ Sjogren's disease
When:_____

☐ Abnormal liver test
When:_____

☐ Anemia
When:_____

☐ Personal history of colon polyps
When:_____

☐ Personal history of colon cancer
When:_____

☐ Gallbladder Disease
When:_____

☐ Stomach ulcer
When:_____

☐ Ulcer of the small intestine
When:_____

☐ Diarrhea
When:_____

☐ Constipation
When:_____

☐ Blood in stool
When:_____

☐ Blood Transfusion
When:_____

☐ Hepatitis A, B, or C
When:_____

☐ Recent ER Visit?
When:_____

☐ Loose or Chipped Teeth?
When:_____

☐ How often do you move your bowels?
When:_____

☐ How many bowel movements per day are normal for you?
When:_____

☐ Cirrhosis
When:_____

☐ GERD
When:_____

☐ Colitis
When:_____

	☐ Diverticulitis When:_____	☐ Barrett's Esophagus When:_____	☐ Celiac Disease When:_____	
Cardiovascular	☐ Atrial Fibrillation When:_____	☐ Coronary Heart Disease When:_____	☐ Deep vein thrombosis When:_____	☐ Endocarditis When:_____
	☐ High blood pressure When:_____	☐ Myocardial infarction/Heart Attack When:_____		
Pulmonary	☐ Asthma When:_____	☐ Emphysema When:_____	☐ Supplemental Oxygen When:_____	☐ COPD When:_____
	☐ Sleep Apnea When:_____			
Other	☐ Arthritis When:_____	☐ Back Pain (chronic) When:_____	☐ Diabetes Mellitus When:_____	☐ Glaucoma When:_____
	☐ Hypothyroidism When:_____	☐ Renal Insufficiency When:_____	☐ HIV When:_____	☐ Hyperthyroidism When:_____
	☐ Do you currently have Chronic Kidney Disease? When:_____			

Previous Procedures

☐ None

☐ Hysterectomy	☐ Appendectomy	☐ Cholecystectomy - Laparoscopic	☐ Problems with anesthesia	☐ Hip/Knee replacement - right/left or both
☐ Pacemaker	☐ Defibrillator	☐ Tubal ligation	☐ Do you have any Metal in your Body? Where? _____	☐ Colon Resection
☐ Stent Placement				

Family Medical History

☐ No knowledge of family history

No family history of

☐ Celiac Sprue
☐ Colon Polyps
☐ Ulcerative colitis/ IBD
☐ Colon Cancer
☐ Liver Disease

	Mother	Father	Sister	Brother	Daughter	Son	Other
Health Status	O	O	O	O	O	O	O
Deceased/At Age	___	___	___	___	___	___	___
Diagnoses							
Crohn's disease	O	O	O	O	O	O	O

Jaundice	○	○	○	○	○	○	○
Hypothyroidism	○	○	○	○	○	○	○
Hepatitis, nonspecific	○	○	○	○	○	○	○
Coronary Heart Disease	○	○	○	○	○	○	○
Cirrhosis, unspecified	○	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○	○
Ulcerative Colitis / IBD	○	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○	○
Celiac disease	○	○	○	○	○	○	○

Social History

Occupation:_____

Marital Status

○ Single ○ Married ○ Divorced ○ Separated ○ Widowed
○ Civil Union ○ Unknown ○ Other

Alcohol

○ None

Type	Quantity	Number	Frequency
○ Less than 7 per week			
○ More than 7 per week			

Caffeine

○ None

○ Artificial sweetener, How many Exposures per day? _____

○ Dairy/Cheese Products used each day? _____

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

Drug Use

○ None

○ Uses IV drugs currently ○ Used IV drugs in the past ○ Recreational drug use ○ tattoos

Exercise

○ None

○ Yes — Type _____ Number _____ Frequency _____

Review Of Systems

Cardiovascular

○ None	Y	N
chest pain	○	○
palpitations	○	○
peripheral edema	○	○

Constitutional

○ None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
weight loss	○	○

ENMT

○ None	Y	N
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
hearing loss	○	○

Endocrine

○ None	Y	N
excessive thirst	○	○
heat intolerance	○	○

Eyes

○ None	Y	N
loss of vision	○	○

Gastrointestinal

○ None	Y	N
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
difficulty swallowing	○	○
stool frequency	○	○

Genitourinary

○ None	Y	N
dark urine	○	○
dysuria	○	○
frequent urination	○	○
hematuria	○	○

Hematologic/Lymphatic

○ None	Y	N
easy bruising	○	○
prolonged bleeding	○	○

Integumentary

○ None	Y	N
itching	○	○
jaundice	○	○
rashes	○	○

Musculoskeletal

○ None	Y	N
back pain	○	○
joint pain	○	○
muscle weakness	○	○

Neurological

○ None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
memory loss	○	○

Psychiatric

○ None	Y	N
anxiety	○	○
depression	○	○

Respiratory

○ None	Y	N
cough	○	○
dyspnea	○	○
excessive sputum	○	○
coughing up blood	○	○
wheezing	○	○