



# Gastroenterology & Hepatology

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## Patient Interview Form

### Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
MRN: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_  
Age: \_\_\_\_\_ Notes: \_\_\_\_\_

### 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  
 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

### Preferred Language

English  Patient declines to specify

### Contact Preference

Patient Portal  Email  Cell Phone  Home Phone  Work Phone  
 Emergency Contact  Patient declines to specify Other: \_\_\_\_\_

## Past or Present Medical Conditions

None

### Cardiovascular

- Atrial Fibrillation     Coronary Artery Disease     Deep vein thrombosis     Endocarditis  
 High blood pressure     Myocardial infarction     Congestive heart failure

### Endocrine

- Hypothyroid     Diabetes insulin controlled     Diabetes oral controlled

### GI

- GERD     Crohn's Disease     Ulcerative Colitis     Diverticulitis  
 Gastric Ulcer     Jaundice     IBS     Diverticulosis  
 Celiac Sprue     Hepatitis (type)     Fecal Urgency/Incontinence     Barrett's Esophagus

### Neurology

- Migraines     Seizure     Stroke

### Pulmonary

- Asthma     COPD     Emphysema

### Renal

- Kidney Stones     Renal Insufficiency

### Personal Cancer History

- Breast Cancer     Uterine Cancer     Colon Cancer     Lung Cancer  
 Prostate Cancer     Other

### Other

- Back Pain     Anxiety     Depression     Fibromyalgia  
 Bleeding Disorder     Arthritis/Degenerative Joint Disease     HIV

## Diagnostic Studies/Tests

None

Colonoscopy

Endoscopy

ERCP

Flexible Sigmoidoscopy

When: \_\_\_\_\_

When: \_\_\_\_\_

When: \_\_\_\_\_

When: \_\_\_\_\_

## Previous Procedures

None

Appendectomy/Appendix Surgery

Back Surgery

C-Section

Cholecystectomy/Gallbladder Surgery

When: \_\_\_\_\_

When: \_\_\_\_\_

When: \_\_\_\_\_

When: \_\_\_\_\_

Cardiac Cath

Type of stent placed

Pacemaker

Defibrillator

Heart Valve Replacement

When: \_\_\_\_\_

When: \_\_\_\_\_

When: \_\_\_\_\_

When: \_\_\_\_\_

When: \_\_\_\_\_

Hysterectomy

Colon Resection

Yearly Physical Exam

Other

When: \_\_\_\_\_

When: \_\_\_\_\_

When: \_\_\_\_\_

When: \_\_\_\_\_

## Social History

Occupation: \_\_\_\_\_ Number of Children: \_\_\_\_\_

### Marital Status

- Single       Married       Divorced       Separated       Widowed  
 Civil Union

### Alcohol

- None
- Type \_\_\_\_\_ Number \_\_\_\_\_
- Rarely \_\_\_\_\_
- Daily \_\_\_\_\_
- More than 2 days/week \_\_\_\_\_
- Less than 2 days/week \_\_\_\_\_
- I quit using alcohol \_\_\_\_\_
- Recovering alcoholic \_\_\_\_\_

### Caffeine

- None
- Occasionally       1-2 Beverages per day       3-4 Beverages per day       5+ Beverages per 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 Currently       Recreational Drug Use Past       Medical Marijuana

### Exercise

- None
- Rarely       Occasionally       2-3 X per week       Daily

## Current Medications

- None

Name	Dose	How taken?
_____	_____	_____

## Allergies

- Patient has no known allergies       Patient has no known drug allergies  
 Codeine Sulfate     Eggs       Penicillins       Erythromycin       Shellfish  
 Topical Anesthetics Novacaine     IV Dye, Iodine Containing Contrast Media     Latex       Sulfa (Sulfonamide Antibiotics)       Aspirin
- Other: \_\_\_\_\_ Other: \_\_\_\_\_

## Family Medical History

- No knowledge of family history  
**No family history of**     Bile Duct Cancer       Celiac disease (disorder)  
                                    Colon Cancer             Colon polyps  
                                    Gastric cancer            IBS  
                                    Inflammatory bowel disease     Liver disease  
                                    Pancreatic cancer         Ulcerative colitis

## Diagnoses

	Mother	Father	Sister	Brother	Daughter	Son	Other
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon polyp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophageal cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Review Of Systems

## Allergic/Immunologic

None Y N  
 HIV exposure    
 persistent infections    
 strong allergic reactions or urticaria

## Cardiovascular

None Y N  
 chest pain    
 shortness of breath with exercise    
 irregular heart beat    
 orthopnea    
 palpitations    
 peripheral edema    
 syncope

## Constitutional

None Y N  
 fatigue    
 fever    
 loss of appetite    
 malaise    
 sweats    
 weight gain    
 weight loss

## ENMT

None Y N  
 difficulty swallowing    
 dizziness    
 ear pain    
 hearing loss    
 nasal obstruction    
 nose bleeds    
 sore throat

## Endocrine

None Y N  
 excessive thirst    
 hair loss    
 heat intolerance

## Eyes

None Y N  
 double vision    
 loss of vision    
 photophobia

## Gastrointestinal

None Y N  
 abdominal pain    
 abdominal swelling    
 black stools    
 change in bowel habits    
 constipation    
 diarrhea    
 difficulty swallowing    
 fullness    
 gas    
 heartburn    
 hoarseness    
 jaundice    
 mucus with stool    
 nausea    
 rectal bleeding    
 rectal pain    
 stomach cramps    
 vomiting

## Genitourinary

None Y N  
 dark urine    
 decrease in urine flow    
 painful urination    
 frequent urinary infections    
 frequent urination    
 blood in urine    
 impotence    
 nocturia    
 urethral discharge or incontinence

## Hematologic/Lymphatic

None Y N  
 bleeding gums or palpable lymph nodes    
 easy bruising    
 prolonged bleeding

## Integumentary

None Y N  
 allergies    
 dryness    
 hives    
 itching    
 jaundice    
 lesions    
 rashes

## Musculoskeletal

None Y N  
 arthritis    
 back pain    
 gout    
 joint deformity    
 joint pain    
 muscle weakness    
 stiffness

## Neurological

None Y N  
 dizziness    
 fainting    
 frequent headaches    
 memory loss    
 migraine    
 numbness or tingling    
 seizures    
 tremors    
 vertigo

## Psychiatric

None Y N  
 anxiety    
 depression    
 difficulty sleeping    
 hallucinations    
 nervousness    
 panic attacks    
 paranoia

## Respiratory

None Y N  
 asthma    
 cough    
 dyspnea    
 excessive sputum    
 coughing up blood    
 shortness of breath with exercise    
 sleep apnea    
 wheezing

**Immunizations**

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- None
- Flu vaccine       Hepatitis A       Hepatitis B       Pneumonia       TB
- When: \_\_\_\_\_      When: \_\_\_\_\_      When: \_\_\_\_\_      When: \_\_\_\_\_      When: \_\_\_\_\_
- Other
- When: \_\_\_\_\_

**Pharmacy**

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Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**Consent to Import Medication History**

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

- Yes       No

**Consent to Share Data**

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

- Yes       No

**Reminder Preference**

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

- Yes       No

**Reviewed with**

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- Patient       Parent       Guardian       Not Present

**Signature**

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Signature \_\_\_\_\_ Date \_\_\_\_\_