GASTROENTEROLOGY ASSOCIATES, P.A.

Board Certified Specialists in Gastrointestinal and Liver Disease

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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

MRN:_____ Date Of Birth:_____

Contact Preference

☐ Email ☐ Telephone call/leave message ☐ Patient declines to specify Other:_____

Email

Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Allergies

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

☐ Aspirin ☐ Codeine ☐ IV Contrast or Iodine ☐ Penicillin ☐ Sulfa (Sulfonamide Antibiotics)

☐ Propofol ☐ Eggs ☐ Latex Other:_____ Other:_____

Immunizations

☐ None

☐ Hepatitis A When:_____ ☐ Hepatitis B When:_____ ☐ Flu Vaccine When:_____ ☐ Pneumonia Vaccine When:_____

Past or Present Medical Conditions

☐ None

Gastrointestinal and Liver

☐ Barrett's Esophagus ☐ Cirrhosis of liver ☐ Colon Cancer ☐ Colon Polyps

☐ Crohn's Disease ☐ Diverticulitis ☐ Diverticulosis ☐ Esophageal Varices

☐ Elevated Liver Enzymes ☐ Fatty liver ☐ Gastric Varices ☐ GERD (reflux / heartburn)

☐ Hepatic encephalopathy ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

☐ Irritable Bowel Syndrome ☐ Liver transplantation ☐ Pancreatitis, acute ☐ Pancreatitis chronic

☐ Stomach or Duodenal Ulcer ☐ Ulcerative Colitis Other:_____ Other:_____

Cardiovascular

☐ Abdominal aortic aneurysm ☐ Atrial Fibrillation ☐ Cardiac valvular disease ☐ Congestive Heart Failure

	☐ Coronary Artery Disease without heart attack	☐ Deep vein thrombosis	☐ Heart Attack	☐ Heart Murmur
	cholesterolemia	☐ Hypertension	☐ Stroke (CVA)	☐ Transient ischemic attack
	Other:	Other:		
Other Conditions	☐ Alcoholism	☐ Anxiety	☐ Alzheimer	☐ Anemia, nonspecific
	☐ Asthma	☐ B12 deficiency Anemia	☐ Breast cancer	☐ Chronic pain syndrome
	☐ Chronic anticoagulation	☐ COPD	☐ Degenerative joint disease	☐ Diabetes Mellitus
	☐ Dialysis	☐ Depression	☐ Drug abuse / dependency	☐ Fibromyalgia
	☐ Glaucoma	☐ Gout	☐ HIV/AIDS	☐ Home Oxygen
	☐ Hyperthyroidism	☐ Hypothyroidism	☐ Iron Deficiency Anemia	☐ Kidney Stones
	☐ Kidney Disease	☐ Kidney Transplant	☐ Lymphoma	☐ Osteoporosis
	☐ Parkinson's disease	☐ PPD positive	☐ Pneumonia	☐ Prostate Cancer
	☐ Rheumatic Fever	☐ Rheumatoid arthritis	☐ Seizure disorder	☐ Skin Cancer
	☐ Tuberculosis	Other:	Other:	

Diagnostic Studies/Tests

☐ None

Gastrointestinal	☐ Colonoscopy When:	☐ EGD (upper endoscopy) When:	☐ ERCP When:	☐ Capsule Endoscopy When:
	☐ Flexible sigmoidoscopy When:	☐ Liver biopsy When:		

Previous Procedures

☐ None Other:

Gastrointestinal Surgery/Procedures	☐ Appendectomy When:	☐ Billroth I When:	☐ Billroth II When:	☐ Cholecystectomy (gall bladder removed) When:
	☐ Colon Resection (part of colon removed) When:	☐ Gastric banding When:	☐ Gastric bypass When:	☐ Hemorrhoid surgery When:
	☐ Hiatal hernia surgery/anti-reflux surgery When:	☐ Lysis of adhesions When:	☐ Partial gastrectomy When:	☐ Small bowel resection When:
	Other:	Other:		
Cardiovascular	☐ Abdominal aortic aneurysm When:	☐ Aortic Valve Replacement When:	☐ Cardiac pacemaker When:	☐ Coronary artery bypass graft (CABG) When:
	☐ Carotid endarterectomy When:	☐ Cardiac stent When:	☐ Cardiac defibrillator When:	☐ Cardiac valve replacement When:
	☐ Mitral valve replacement When:	☐ Peripheral vascular surgery When:	Other:	Other:

Other

Surgery/Procedure

- ◯ Breast Cancer Surgery — When: _____ When: _____
- ◯ C-Section — When: _____
- ◯ Groin hernia — When: _____
- ◯ Hysterectomy — When: _____
- ◯ Prostatectomy — When: _____
- ◯ Thyroid — When: _____
- ◯ Tonsillectomy — When: _____
- ◯ Total hip replacement — When: _____
- ◯ Total knee replacement — When: _____
- ◯ Tubal Ligation — When: _____
- Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

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

Alcohol

◯ None

Type	Quantity	Number	Frequency
◯ Example - Wine	Glass	2	Times / week
◯ Beer			
◯ Wine			
◯ Other			

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

- ◯ I have never used recreational drugs
- ◯ I have used recreational drugs in the past
- ◯ I currently use recreational drugs
- ◯ I have been treated for substance abuse

Type: _____

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								
Healthy	○	○	○	○	○	○	○	○
	○	○	○	○	○	○	○	○
Deceased/At Age	____	____	____	____	____	____	____	____
Diagnoses								
Colon polyps	○	○	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○	○	○
Alcoholism	○	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○	○
Bleeding tendency	○	○	○	○	○	○	○	○
Cancer (other)-specify type if known	○	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○	○
Heart attack	○	○	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

○ None	Y	N
Allergies (environmental)	○	○
Recurrent hives	○	○
other	○	○

Cardiovascular

○ None	Y	N
chest pain	○	○
shortness of breath with exertion	○	○
shortness of breath-lying flat	○	○
palpitations	○	○
Ankle swelling	○	○
other	○	○

Constitutional

○ None	Y	N
fatigue	○	○
weight gain	○	○
weight loss	○	○
other	○	○

ENMT

○ None	Y	N
nose bleeds	○	○
sore throat	○	○
hearing loss	○	○
other	○	○

Endocrine

○ None	Y	N
excessive thirst	○	○
hair loss	○	○
cold intolerance	○	○
other	○	○

Eyes

○ None	Y	N
Visual decline	○	○
other	○	○

Gastrointestinal

○ None	Y	N
abdominal pain	○	○
black tarry stools	○	○
bloating	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
difficulty swallowing	○	○
heartburn	○	○
milk/dairy intolerance	○	○
mucous in stool	○	○
nausea	○	○
pain with bowel movement	○	○
rectal bleeding	○	○
rectal urgency	○	○
soiling stool	○	○
vomiting	○	○
other	○	○

Genitourinary

○ None	Y	N
frequent urinary infections	○	○
change in urinary frequency	○	○
kidney disease/failure	○	○
other	○	○

Hematologic/Lymphatic

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

Integumentary

○ None	Y	N
dryness	○	○
hives	○	○
itching	○	○
rashes	○	○
other	○	○

Musculoskeletal

○ None	Y	N
joint pain	○	○
joint swelling	○	○
muscle pain	○	○
other	○	○

Neurological

○ None	Y	N
dizziness	○	○
frequent headaches	○	○
numb extremities	○	○
other	○	○

Psychiatric

○ None	Y	N
anxiety/panic	○	○
depression	○	○
suicidal thoughts	○	○
other	○	○

Respiratory

○ None	Y	N
cough	○	○
excessive sputum	○	○
shortness of breath	○	○
wheezing	○	○
cough up blood	○	○
other	○	○

Pharmacy

Name Address Phone

Current Medications

☐ None

Name	Dose	How taken?

Consent to Import Medication History

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

☐ Yes ☐ No

Reminder Preference

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

☐ Yes ☐ No

Consent to Share Data

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

☐ Yes ☐ No

Signature

Signature Date