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	☐ Defibrilator
When:_____	When:_____	When:_____	When:_____
☐ Heart Valve Replacement			
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
- ☐ Colon Cancer
- ☐ Gastric cancer
- ☐ Inflammatory bowel disease
- ☐ Pancreatic cancer
- ☐ Celiac disease (disorder)
- ☐ Colon polyps
- ☐ IBS
- ☐ Liver disease
- ☐ Ulcerative colitis

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Other
Celiac Disease	○	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○	○
Colon polyp	○	○	○	○	○	○	○
Esophageal cancer	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○	○

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

☐ None

☐ Flu vaccine When:_____ ☐ Hepatitis A When:_____ ☐ Hepatitis B When:_____ ☐ Pneumonia When:_____ ☐ TB When:_____

☐ Other

When:_____

Pharmacy

Name Address Phone

Consent to Import Medication History

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

☐ Yes ☐ No

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

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

Signature

Signature Date