GASTRO HEALTH

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Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

Date Of Birth: _____

Race

☐ White/Caucasian ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander ☐ Unknown ☐ Patient declines to provide information

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to provide information

Gender

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ French ☐ Creole ☐ Portuguese ☐ Spanish

Other: _____ ☐ Patient declines to specify

ALLERGIES

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

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

☐ Penicillins ☐ Sulfa (Sulfonamides) ☐ Latex ☐ Soy Other: _____

IMMUNIZATIONS

☐ None

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

☐ Shingles When: _____ ☐ Tetanus When: _____ ☐ Other: _____

PAST OR PRESENT MEDICAL CONDITIONS

☐ None

☐ AICD/Pacemaker ☐ Anemia ☐ Angina ☐ Anxiety Disorder ☐ Arthritis ☐ Asthma

☐ Blood Clots ☐ Cancer - Breast ☐ Cancer - Colon ☐ Cancer - Head/Neck ☐ Cancer - Leukemia / Lymphoma

☐ Cancer - Lung ☐ Cancer - Prostate ☐ Cancer - Skin ☐ Cancer - Other ☐ Celiac Disease

☐ Chronic Lung Disease ☐ Cirrhosis of Liver ☐ Colitis ☐ Colon Polyps ☐ Crohn's Disease ☐ Depression ☐ Diabetes

☐ Diverticulitis ☐ Endometriosis ☐ Fatty Liver ☐ Fibromyalgia ☐ Gallstones ☐ Gastroesophageal Reflux Disease (GERD)

☐ Glaucoma ☐ Heart Failure ☐ Helicobacter Pylori ☐ Hemorrhoids ☐ Hepatitis A ☐ Hepatitis B

☐ Hepatitis C ☐ Hepatitis Other ☐ Hernia - Abdominal Wall ☐ Hernia - Inguinal ☐ Hernia - Umbilical

☐ High Blood Pressure ☐ High Cholesterol ☐ High Triglycerides ☐ HIV/AIDS ☐ Irritable Bowel Syndrome

☐ Kidney Disease/Failure ☐ Kidney Stone ☐ Lactose Intolerance ☐ Lupus ☐ Multiple Sclerosis

☐ Myocardial Infarction ☐ Osteoporosis ☐ Ovarian Cyst ☐ Pancreatitis ☐ Parkinson's ☐ Pneumonia

☐ Polio ☐ Positive PPD ☐ Psoriasis ☐ Pulmonary Embolus ☐ Rheumatic Fever ☐ Seizures

☐ Sexually Transmitted Disease ☐ Sleep Apnea ☐ Stomach / Duodenal Ulcer ☐ Stroke ☐ TB (Tuberculosis) ☐ TB Skin Test (Positive)

☐ Thyroid Disease ☐ Ulcerative Colitis ☐ Uterine Fibroids ☐ Other: _____

DIAGNOSTIC STUDIES / TESTS

◯ None

◯ Colonoscopy When: _____ ◯ EGD When: _____ ◯ ERCP When: _____ ◯ Liver Biopsy When: _____ ◯ Enteroscopy When: _____

◯ EUS When: _____ ◯ Capsule Endoscopy When: _____ ◯ Stress Test When: _____ ◯ Echocardiogram When: _____

PREVIOUS PROCEDURES

◯ None

◯ Abdominoplasty Tummy Tuck When: _____ ◯ Appendectomy When: _____ ◯ Bariatric Surgery - Gastric Banding When: _____ ◯ Bariatric Surgery - Gastric Bypass When: _____ ◯ Bariatric surgery- Gastric Sleeve When: _____

◯ Bladder Surgery When: _____ ◯ Breast When: _____ ◯ C-Section When: _____ ◯ Colon Resection When: _____ ◯ Colostomy When: _____

◯ Coronary Bypass When: _____ ◯ Fundoplication When: _____ ◯ Gallbladder Surgery When: _____ ◯ Hemorrhoid Surgery When: _____ ◯ Hysterectomy When: _____

◯ Inguinal Hernia Repair When: _____ ◯ Ovary Surgery When: _____ ◯ Prostate When: _____ ◯ Stomach When: _____ ◯ Thyroid When: _____

◯ Tubal Ligation When: _____ ◯ Umbilical Hernia Repair When: _____ ◯ Other _____ When: _____

SOCIAL HISTORY

Occupation: _____ Number of Children: _____

Marital Status

◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Alcohol

◯ None

Type	Quantity	Number
◯ Rarely		
◯ Less than 2 days/week		
◯ More than 2 days/week		
◯ Daily		
◯ I quit using		

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	Frequency
◯ Cigarettes				
◯ Cigar				
◯ Chewing Tobacco				
◯ Pipe				

Drug Use

◯ None

Type	Number		Number
◯ I have never used recreational drugs		◯ I have used recreational drugs in the past	
◯ I am currently using recreational drugs		◯ I have been treated for substance abuse	

CURRENT MEDICATIONS

◯ None

Name	Dose	How Taken?

PHARMACY

Name _____ Phone Number _____

REVIEW OF SYSTEMS

Constitutional

☐ None

	Yes	No
fatigue	○	○
fever	○	○
night sweats	○	○
weight loss	○	○
weight gain	○	○

Gastrointestinal

☐ None

	Yes	No
abdominal pain	○	○
abdominal swelling	○	○
belching	○	○
bloating	○	○
blood in stool	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
hemorrhoids	○	○
jaundice	○	○
nausea	○	○
vomiting	○	○
poor appetite	○	○
rectal bleeding	○	○
rectal pain	○	○
soiling/incontinence	○	○
trouble swallowing	○	○

Cardiovascular

☐ None

	Yes	No
chest pain with activity	○	○
shortness of breath with exercise	○	○
shortness of breath when lying down	○	○
pain in legs with walking	○	○
palpitations	○	○
swelling in the legs	○	○
fainting	○	○

Respiratory

☐ None

	Yes	No
cough	○	○
shortness of breath	○	○
excessive mucus or phlegm	○	○
cough up blood	○	○
wheezing	○	○

Genitourinary

☐ None

	Yes	No
breast enlargement or pain	○	○
breast lump	○	○
change in urinary frequency	○	○
dark urine	○	○
decrease in urine flow	○	○
painful urination	○	○
heavy periods	○	○
blood in urine	○	○
impotence	○	○
urethral discharge	○	○
urinary incontinence	○	○

Eyes

☐ None

	Yes	No
change of vision	○	○
double vision	○	○
eye pain	○	○
photophobia	○	○

Integumentary

☐ None

	Yes	No
itching	○	○
lesions/nodules	○	○
rash	○	○
tattoos	○	○

Neurological

☐ None

	Yes	No
dizziness/lightheadedness	○	○
fainting	○	○
headaches	○	○
numbness/tingling	○	○
tremors	○	○
weakness in arms	○	○
weakness in legs	○	○

Endocrine

☐ None

	Yes	No
abnormal growth of hair	○	○
abnormal loss of hair	○	○
cold intolerance	○	○
excessive thirst	○	○
hot flashes	○	○

Psychiatric

☐ None

	Yes	No
abnormal sleep	○	○
anxiety/nervousness	○	○
depression	○	○
hallucinations	○	○
memory loss/confusion	○	○
panic attacks	○	○
suicidal thoughts	○	○

ENMT

☐ None

	Yes	No
bleeding gums	○	○
ear pain	○	○
hearing loss	○	○
hoarseness	○	○
mouth sores	○	○
nasal obstruction	○	○
nose bleeds	○	○
sore throat	○	○
sinus problems	○	○

Musculoskeletal

☐ None

	Yes	No
back pain	○	○
joint pain	○	○
muscle tenderness	○	○
swollen joints	○	○

Hematologic/Lymphatic

☐ None

	Yes	No
easy bleeding	○	○
enlarged glands	○	○
frequent bruising	○	○

Allergic/Immunologlc

☐ None

	Yes	No
persistent infections	○	○
strong allergic reactions or hives	○	○

FAMILY MEDICAL HISTORY

☐ No knowledge of family history

No family history of

☐ Colon Cancer ☐ Colon Polyps
☐ Crohn's Disease ☐ Liver Disease
☐ Ulcerative Colitis

Health Status	Mother	Father	Sister	Brother	Grandmother	Grandfather
Healthy	○	○	○	○	○	○
Deceased / at Age						
Diagnoses						
Alcoholism	○	○	○	○	○	○
Bleeding Disorders	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○
Heart Trouble	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○
Stroke	○	○	○	○	○	○
Thyroid Disease	○	○	○	○	○	○
Ulcer Disease	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Age diagnosed						