GASTROINTESTINAL HEALTHCARE
Improving Your Health From The Inside Out.
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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:_____

Effective January 1, 2010 all freestanding surgical facility providers are required to report to the Division of Public Health any self-reported race and ethnicity data provided by the patient. If you choose to self-report this information, please bubble in the appropriate race and ethnicity. If you choose not to report this information, please select "Patient declines to provide information" in both sections.

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

Ethnicity

◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Patient declines to specify

Sex

◯ Male ◯ Female ◯ Other

Preferred Language

◯ English ◯ Spanish; Castilian ◯ Patient declines to specify Other:_____

Contact Preference

◯ Home phone ◯ Business phone ◯ Cell phone ◯ Mail ◯ Email
◯ Patient declines to specify

Allergies

◯ Patient has no known allergies ◯ Patient has no known drug allergies

◯ NC Latex ◯ Adhesive Tape ◯ NC Soy ◯ NC Nuts ◯ NC Eggs
◯ NC Mangoes ◯ Propofol ◯ Fentanyl ◯ Midazolam ◯ Lidocaine
◯ Iodine ◯ Morphine ◯ Codeine ◯ Penicillins ◯ Sulfa
◯ Aspirin Other:_____ Other:_____ Other:_____ Other:_____

Current Medications and dosages, including over-the-counter & supplements

◯ None

Name:_____ Name:_____
Name:_____ Name:_____
Name:_____ Name:_____
Name:_____ Name:_____
Name:_____ Name:_____

Immunizations

- [ ] None
- [ ] Hep A, adult
- [ ] Hep B, adult

Other: _____

Diagnostic Studies/Tests

- [ ] None
- [ ] CT Scan
- [ ] Ultrasound
- [ ] Colonoscopy
- [ ] Endoscopy
- [ ] Sigmoidoscopy

Past or Present Medical Conditions

- [ ] None
- [ ] Acid Reflux
- [ ] Anemia
- [ ] Asthma
- [ ] Atrial Fibrilation
- [ ] Back Pain (chronic)
- [ ] Breast cancer
- [ ] Cancer
- [ ] Chronic Lung Disease
- [ ] Cirrhosis
- [ ] Colitis
- [ ] Colon Cancer
- [ ] Colon Polyps
- [ ] Congestive Heart Failure
- [ ] Crohn's Disease
- [ ] Diabetes
- [ ] Diarrhea
- [ ] Diverticulitis
- [ ] Diverticulosis
- [ ] Depression
- [ ] Emphysema
- [ ] Fatty Liver
- [ ] Frequent Urinary Tract Infections
- [ ] Gallstones
- [ ] Gastric Ulcer
- [ ] Glaucoma
- [ ] Gout
- [ ] Heart Attack
- [ ] Heart Murmurs
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] Hiatal Hernia
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] High Triglycerides
- [ ] History of Suicide Attempts
- [ ] HIV/AIDS
- [ ] Irregular Heartbeat
- [ ] Irritable Bowel Syndrome
- [ ] Kidney Disease
- [ ] Kidney Failure
- [ ] Kidney Stones
- [ ] Lactose Intolerance
- [ ] Lupus
- [ ] Migraines
- [ ] Mitral Valve Prolapse
- [ ] Myocardial Infarction
- [ ] Neurological Disorders
- [ ] Osteoarthritis
- [ ] Pancreatitis
- [ ] Parkinson's Disease
- [ ] Phlebitis
- [ ] Pneumonia
- [ ] Positive TB Skin Test
- [ ] Rheumatic Fever
- [ ] Rheumatoid Arthritis
- [ ] Seizures
- [ ] Skin Cancer
- [ ] Sleep Apnea
- [ ] Stroke
- [ ] Thyroid Disease
- [ ] TMJ
- [ ] Tuberculosis
- [ ] Uterine Cancer

Previous Procedures

- [ ] None
- [ ] Appendectomy
- [ ] Breast Surgery
- [ ] C-Section
- [ ] Cardiac Catheter
- [ ] Colon Resection
- [ ] Defibrillator
- [ ] Gallbladder
- [ ] Heart Bypass
- [ ] Heart Stent
- [ ] Heart Valve Replacement
- [ ] Hemorrhoid
- [ ] Hernia Repair
- [ ] Hysterectomy
- [ ] Joint Replacement
- [ ] Kidney
- [ ] Liver Biopsy
- [ ] Obesity
- [ ] Pacemaker
- [ ] Prostate Surgery
- [ ] Stomach
- [ ] Thyroid
- [ ] Tonsillectomy
- [ ] Transplant
- [ ] Tubal Ligation
- [ ] Vasectomy

Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Civil Union

Alcohol

- ☐ None
- ☐ Rarely
- ☐ Less than two days per week
- ☐ More than two days per week
- ☐ Daily
- ☐ I quit using alcohol

Caffeine

- ☐ None
- ☐ Coffee
- ☐ Tea
- ☐ Soda

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
- ☐ Tylenol/Acetominophen
- ☐ Advil/Ibuprofen
- ☐ Aleve/Naproxen
- ☐ Aspirin

Exercise

- ☐ None
- ☐ I walk
- ☐ I jog
- ☐ I bike
- ☐ I swim
- ☐ I golf
- ☐ I do aerobics
- ☐ I lift weights

Family Medical History

- ☐ No knowledge of family history

No family history of

- ☐ Colon cancer
- ☐ Polyps

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Other
Colitis	○	○	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○	○	○	○
Gallbladder Disease	○	○	○	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○	○
Ulcer Disease	○	○	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic
None

	Yes	No
HIV exposure	○	○
recurrent infections	○	○
strong allergic reactions or rashes	○	○

Cardiovascular
None

	Yes	No
chest pain	○	○
shortness of breath with exercise	○	○
irregular heart beat	○	○
shortness of breath when lying flat	○	○
palpitations	○	○
swelling of the lower limbs	○	○
fainting	○	○

Constitutional
None

	Yes	No
extreme exhaustion	○	○
fever	○	○
loss of appetite	○	○
general discomfort or uneasiness	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

ENMT
None

	Yes	No
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
difficulty breathing through nose	○	○
nose bleeds	○	○
sore throat	○	○
jaw pain, popping	○	○

Endocrine
None

	Yes	No
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Eyes
None

	Yes	No
seeing double	○	○
loss of vision	○	○
light sensitivity	○	○

Gastrointestinal
None

	Yes	No
abdominal bloating	○	○
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
difficulty swallowing	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○

Genitourinary
None

	Yes	No
dark urine	○	○
decrease in urine flow	○	○
painful urination	○	○
frequent urinary infections	○	○
frequent urination	○	○
blood in urine	○	○
impotence	○	○
nighttime urination	○	○
urethral discharge or incontinence	○	○

Hematologic/Lymphatic
None

	Yes	No
bleeding gums or swollen glands	○	○
easy bruising	○	○
prolonged bleeding	○	○

Integumentary
None

	Yes	No
allergies	○	○
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○

Musculoskeletal
None

	Yes	No
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological
None

	Yes	No
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○
vertigo	○	○

Psychiatric
None

	Yes	No
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
history of suicide attempt	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Respiratory
None

	Yes	No
asthma	○	○
cough	○	○
difficulty breathing	○	○
excessive saliva	○	○
coughing up blood	○	○
shortness of breath with exercise	○	○
wheezing	○	○

Name of patient's pharmacy: _____

Consent to Import Medication History

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

This allows us to obtain current, accurate information regarding your prescription medications, which helps us to identify potentially dangerous drug interactions.

○ Yes ○ No

Consent to Share Data

I consent to allow GIH to share my medical and demographic information between providers related to my course of treatment, such as my primary care or referring physician.

☐ Yes ☐ No

Reminder Preference

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

GIH would like to provide you with medical treatment reminders at the recommendation of your physician.

☐ Yes ☐ No

Patient signature: _____ Date:_____

For office use only:

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present