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 Portal
- ⬭ Patient declines to specify

Allergies

- ⬭ Patient has no known allergies
- ⬭ Patient has no known drug allergies

- ⬭ NC Latex
- ⬭ Adhesive Tape
- ⬭ Soy
- ⬭ NC Nuts
- ⬭ NC Eggs
- ⬭ NC Mangoes
- ⬭ Nickel
- ⬭ Propofol
- ⬭ Fentanyl
- ⬭ Midazolam
- ⬭ Lidocaine
- ⬭ Iodine
- ⬭ Morphine
- ⬭ Codeine
- ⬭ Penicillins
- ⬭ Sulfa
- ⬭ Aspirin
- 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	Flu vaccine	Pneumonia
When:______	When:______	When:______	When:______

Diagnostic Studies/Tests

- None

CT Scan	Ultrasound	Colonoscopy	Endoscopy	Sigmoidoscopy

Past or Present Medical Conditions

- None

Acid Reflux	Anemia	Asthma	Atrial Fibrillation	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 w/CPAP	Sleep Apnea - No CPAP
Stroke	Thyroid Disease	TMJ	Tuberculosis	Uterine Cancer
I, the patient, have traveled outside the US in the past 21 days.	Do you currently have any of the following symptoms?	Fever	Productive cough	Unexpected weight loss
Night sweats				

Previous Procedures

- None

Appendectomy	Breast Surgery R or L	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:______	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
- Colon 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 Current Symptoms

Allergic/Immunologic

◯ None	Y	N
HIV exposure	◯	◯
recurrent infections	◯	◯
strong allergic reactions or rashes	◯	◯

Cardiovascular

◯ None	Y	N
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	Y	N
extreme exhaustion	◯	◯
fever	◯	◯
loss of appetite	◯	◯
general discomfort or uneasiness	◯	◯
sweats	◯	◯
weight gain	◯	◯
weight loss	◯	◯

ENMT

◯ None	Y	N
difficulty swallowing	◯	◯
dizziness	◯	◯
ear pain	◯	◯
difficulty breathing through nose	◯	◯
nose bleeds	◯	◯
sore throat	◯	◯
jaw pain, popping	◯	◯

Endocrine

◯ None	Y	N
excessive thirst	◯	◯
hair loss	◯	◯
heat intolerance	◯	◯

Eyes

◯ None	Y	N
seeing double	◯	◯
loss of vision	◯	◯
light sensitivity	◯	◯

Gastrointestinal

◯ None	Y	N
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	Y	N
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	Y	N
bleeding gums or swollen glands	◯	◯
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	◯	◯
migraine	◯	◯
numbness or tingling	◯	◯
seizures	◯	◯
tremors	◯	◯
vertigo	◯	◯

Psychiatric

◯ None	Y	N
anxiety	◯	◯
depression	◯	◯
difficulty sleeping	◯	◯
hallucinations	◯	◯
history of suicide attempt	◯	◯
nervousness	◯	◯
panic attacks	◯	◯
paranoia	◯	◯

Respiratory

◯ None	Y	N
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