GASTRO HEALTH

www.GastroHealth.com

PATIENT INTERVIEW FORM

PATIENT INFORMATION

First Name:_____ Last Name: _____

Date of Birth: _____

Race

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

☐ Native Hawaiian or Other Pacific Islander ☐ Mixed ☐ Other ☐ 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 ☐ Portuguese ☐ Spanish ☐ Creole ☐ Other: _____

PHARMACY

Name:_____ Phone Number _____

CURRENT MEDICATIONS

☐ None

Name	Dose	How Taken?

PAST OR PRESENT MEDICAL CONDITIONS

- [ ] None
- [ ] AICD/Pacemaker
- [ ] Anemia
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune Disease
- [ ] Bleeding Problems
- [ ] Cancer - Colon
- [ ] Cancer - Other
- [ ] Celiac Disease
- [ ] Chest Pain
- [ ] Cirrhosis of Liver
- [ ] Colon Polyps
- [ ] Crohn's Disease
- [ ] Depression
- [ ] Diabetes
- [ ] Diverticulitis
- [ ] Fatty Liver
- [ ] Fibromyalgia
- [ ] Gallbladder Disease
- [ ] Gastroesophageal Reflux Disease (GERD)
- [ ] Glaucoma
- [ ] Heart Disease
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] HIV/AIDS
- [ ] Irritable Bowel Syndrome
- [ ] Kidney Disease/Failure
- [ ] Lactose Intolerance
- [ ] Liver Disease
- [ ] Lung Disease
- [ ] Multiple Sclerosis
- [ ] Neurologic Disorders
- [ ] Pancreatitis
- [ ] Prostate Enlargement
- [ ] Sleep Apnea
- [ ] Stomach / Duodenal Ulcer
- [ ] Stroke
- [ ] TB (Tuberculosis)
- [ ] Thyroid Disease
- [ ] Ulcerative Colitis
- [ ] Other _____

ALLERGIES

- [ ] Patient has no known allergies
- [ ] Aspirin
- [ ] Codeine Sulfate
- [ ] Eggs
- [ ] Iodine/Iodine-Containing Products
- [ ] Morphine
- [ ] Penicillin's
- [ ] Sulfa (Sulfonamides)
- [ ] Latex
- [ ] Soy
- [ ] 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 When: _____
- [ ] Breast When: _____
- [ ] Bladder Surgery When: _____
- [ ] Coronary Bypass Surgery When: _____
- [ ] Breast When: _____
- [ ] C-Section When: _____
- [ ] Colon Resection When: _____
- [ ] Colostomy When: _____
- [ ] Hysterectomy Surgery When: _____
- [ ] Colon Resection When: _____
- [ ] Hiatal Hernia Repair When: _____
- [ ] Gallbladder Surgery When: _____
- [ ] Hemorrhoid Surgery When: _____
- [ ] Stomach When: _____
- [ ] Inguinal Hernia Repair When: _____
- [ ] Ovary Surgery When: _____
- [ ] Prostate When: _____
- [ ] Thyroid When: _____
- [ ] Umbilical Hernia Repair When: _____
- [ ] Other _____

FAMILY MEDICAL HISTORY

☐ No knowledge of family history

No family history of ☐ Colon Cancer ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Colon Polyps ☐ Liver Disease

Health Status	Mother	Father	Sister	Brother	Grandmother	Grandfather
Healthy	☐	☐	☐	☐	☐	☐
Deceased / at Age	_____	_____	_____	_____	_____	_____
Diagnoses						
Celiac Disease	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐
Ulcer Disease	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Occupation:_____ Number of Children: _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Alcohol

None ☐

	Type	Quantity
☐ Rarely		
☐ Less than 2 days/week		
☐ More than 2 days/		
☐ week I quit using		

Tobacco

Smoking Status ☐ Current daily smoker ☐ Current weekly smoker ☐ Former smoker ☐ Never smoker

☐ Smoker, current status unknown ☐ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
☐ Cigarettes				
☐ Cigar				
☐ Chewing Tobacco				
☐ Pipe				

Drug Use

☐ None

Type

☐ 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

REVIEW OF SYSTEMS

CONSTITUTIONAL
☐ None

Yes	No	
☐	☐	fatigue
☐	☐	fever
☐	☐	weight loss

RESPIRATORY
☐ None

Yes	No	
☐	☐	cough
☐	☐	shortness of breath

CARDIOVASCULAR
☐ None

Yes	No	
☐	☐	chest pain
☐	☐	palpitations

GASTROINTESTINAL
☐ None

Yes	No	
☐	☐	gas
☐	☐	heartburn
☐	☐	nausea
☐	☐	vomiting
☐	☐	trouble swallowing
☐	☐	abdominal pain
☐	☐	change in bowel habits
☐	☐	constipation
☐	☐	diarrhea
☐	☐	soiling/incontinence
☐	☐	rectal bleeding
☐	☐	rectal pain
☐	☐	hemorrhoids
☐	☐	jaundice

HEMATOLOGIC/LYMPHATIC
☐ None

Yes	No	
☐	☐	easy bruising/bleeding

GENITOURINARY
☐ None

Yes	No	
☐	☐	dark urine

MUSCULOSKELETAL
☐ None

Yes	No	
☐	☐	joint pain

INTEGUMENTARY
☐ None

Yes	No	
☐	☐	rash

NEUROLOGICAL
☐ None

Yes	No	
☐	☐	headaches

PSYCHIATRIC
☐ None

Yes	No	
☐	☐	anxiety/depression
☐	☐	memory loss/confusion

IMMUNIZATIONS
☐ None

☐ Flu When:_____
☐ Hepatitis A When:_____
☐ Hepatitis B When:_____
☐ Pneumonia When:_____
☐ HPV When:_____
☐ Shingles When:_____
☐ Tetanus When:_____
☐ Other: When:_____