GASTRO HEALTH

Patient Interview Form

PLACE PATIENT LABEL HERE

Patient email_____

Name: _____ **Birth Date**: _____ **Gender**: _____

Race: (check any that apply) ❒ White/Caucasian ❒ Black or African-American ❒ Asian ❒ American Indian or Alaska Native ❒ Native Hawaiian or Pacific Islander ❒ Unknown ❒ Patient Declines to Specify ❒ Prohibited by state law

Ethnicity: (check one) ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Patient Declines to Specify.

Preferred Language: ❒ English ❒ Spanish ❒ Chinese ❒ Russian ❒ Patient Declines to Specify ❒ Other_____

Contact Preference: ❒ Letter ❒ Portal (Email) ❒ Patient Declines to Specify

Referring Physician: _____ **Primary Care Physician**: _____

Local Pharmacy Name/ Address: _____

Mail-Order Pharmacy Name/ Address: _____

PRESENTING PROBLEM: Use the space below to describe the reason for your visit and your special concerns. If you have questions, please write them down so you will not forget them. Thank you.

MEDICATION ALLERGIES: List the medications or injections that have caused bad reactions. Include your reaction (hives, rash, itching, headache, nausea, diarrhea, passed out, shock, shortness of breath).

Medication / Dose	Reaction		Medication / Dose	Reaction

Do you have a allergies to following ❒ NO If yes check box and describe reaction:
❒ Latex_____ **❒ Eggs**_____ **❒ Soy** _____

MEDICATIONS: Please list the medications that you are taking (prescription, over-the-counter, and supplements), including any **NSAIDs or Anti-inflammatory medications** that you are currently taking (Aspirin, Advil/ibuprofen, Aleve/naproxen, Celebrex (celecoxib), Voltaren (diclofenac): Attach additional sheet if needed.

Medication/ Dose	How often per day?		Medication/ Dose	How often per day?

IMMUNIZATIONS: Have you been immunized for any of the following?

❒ Flu vaccine	❒ Hep A	❒ Hep B	❒ Pneumonia vaccine	❒ Herpes zoster (shingles) vaccine
When: _____	When: _____	When: _____	When: _____	When: _____

Cardiac

❒ **Abnormal Heartbeats** ❒ **Angina** ❒ **Artificial Heart Valve** ❒ **Cardiac Stents**
❒ **Congestive Heart Failure** ❒ **Defibrillator** ❒ **Hyperlipidemia** ❒ **Hypertension**
❒ **Heart Attack** ❒ **Pacemaker** (Elevated Cholesterol) (High Blood Pressure)

❒ **Other Heart Trouble** (List):_____

Respiratory

❒ **Asthma** ❒ **COPD** ❒ **Emphysema** ❒ **Pneumonia** ❒ **Sleep Apnea** ❒ **TB Exposure/ Treatment**

Gastrointestinal

❒ **Cancer of the GI Tract** ❒ **Crohn's** ❒ **Colon Cancer** ❒ **Colon Polyps**
❒ **Diverticulitis** ❒ **Eating Disorder** ❒ **Fecal Incontinence** ❒ **Heartburn**
❒ **Hemorrhoids** ❒ **Hepatitis A** ❒ **Hepatitis B** ❒ **Hepatitis C**
❒ **Hernia** ❒ **Irritable Bowel** ❒ **Jaundice**(yellow eyes / skin) ❒ **Peptic Ulcer**
❒ **Ulcerative Colitis**

GYN / OB (Female must complete)

Number of Pregnancies_____ ❒ **Menstrual or Pelvic Problems** ❒ **Date of Last Period** _____ ❒**Birth Control Method**_____
Number of Live births_____ ❒ **Endometriosis** ❒**Hysterectomy** ❒**Tubal Ligation** ❒ **Menopause greater than 6 months**

Other

❒ **Diabetes** ❒ **Thyroid Disorder** ❒ **Bladder Infections** ❒ **Blood in Urine**
❒ **Kidney Failure** ❒ **Kidney Stones** ❒ **Depression** ❒ **Anxiety Disorder**
❒ **Severe Headaches** ❒ **Sexually Transmitted Disease** ❒ **Seizures** (fits or blackouts) ❒ **Anemia**
❒ **Stroke**, **Mini-stroke** (TIA/CVA) ❒ **Abnormal Bleeding** ❒ **Arthritis** ❒ **Back Pain** (chronic)
❒ **Blood Transfusions** ❒ **Osteoporosis** ❒ **Victim of Verbal Abuse/ Violence**
❒ **History of MRSA**

❒ **Collagen Vascular Disease** (lupus, scleroderma, vasculitis, other)
❒ **Other Medical Conditions** (List):_____
_____

❒ **Other cancers** (list)_____
_____
_____

Hospitalizations for Past Illnesses	**Year**	**Hospital**	**Physician**
Procedures or Surgeries	**Year**	**Hospital**	**Physician**
Diagnostic Studies or Tests (include previous colonoscopy & upper endoscopy)	**Year**	**Hospital**	**Physician**

Social History

Occupation _____ **Marital Status** _____ **Number of Children** _____

Alcohol Use
Amount? **Frequency?**
❒ Beer _____Per _____
❒ Wine _____Per _____
❒ Spirits_____ Per _____
❒ Never

Caffeine Use
❒ Diet Soda
❒ Soda
❒ Coffee
❒ Tea
❒ Never

Tobacco Use
❒ Light smoker (< 10 cigarettes/day)
❒ Heavy smoker (>10 cigarettes/day)
Date Started _____
❒ Former smoker quit: Year _____
❒ Other/Vape/eCig ❒ Never smoker

Recreational Drug / Marijuana Use
❒ Never ❒ Yes (see below)
❒ Marijuana: ❒ edible ❒ smoke ❒ topical
❒ Other _____
Frequency _____
❒ Former quit: year _____

Exercise ❒ Yes ❒ No Frequency _____
Type _____

PLACE PATIENT LABEL HERE

Family Medical History ❒ **No knowledge of family history.**

❒ **No Family History of Colon Cancer.** ❒ **No Family History of Colon Polyps.**

Mother: Living? ❒ Yes ❒ No Age now, or at death _____ **Father**: Living? ❒ Yes ❒ No Age now, or at death _____

Besides parents, do you have any brothers, sisters, sons or daughters with the following conditions? Fill in the blanks with their relation to you and mark the condition (please specify living or deceased).

Any Family History Of:	**Mother**	**Father**						
Abnormal Bleeding	❒	❒	❒	❒	❒	❒	❒	❒
Celiac Disease	❒	❒	❒	❒	❒	❒	❒	❒
Colon Cancer	❒	❒	❒	❒	❒	❒	❒	❒
Colon Polyps	❒	❒	❒	❒	❒	❒	❒	❒
Crohn's	❒	❒	❒	❒	❒	❒	❒	❒
Ulcerative Colitis	❒	❒	❒	❒	❒	❒	❒	❒
Diabetes	❒	❒	❒	❒	❒	❒	❒	❒
High Blood Pressure	❒	❒	❒	❒	❒	❒	❒	❒
Liver Disease	❒	❒	❒	❒	❒	❒	❒	❒
Other Cancer	❒	❒	❒	❒	❒	❒	❒	❒
Peptic Ulcer	❒	❒	❒	❒	❒	❒	❒	❒
Heart Attack	❒	❒	❒	❒	❒	❒	❒	❒
Stroke	❒	❒	❒	❒	❒	❒	❒	❒
Cause of Death								

Have You Had Any of These Symptoms in the Last 6 Months? (Check any that apply)

Cardiovascular	**Gastrointestinal**	**Musculoskeletal**
❒ Chest pain	❒ Abdominal pain	❒ Arthritis
❒ Irregular heart beat	❒ Abdominal swelling	❒ Back pain
❒ Difficulty breathing while lying down	❒ Change in bowel habits	❒ Gout
❒ Palpitations	❒ Constipation	❒ Joint deformity
❒ Swelling of your arms or legs	❒ Diarrhea	❒ Joint pain
❒ Short of breath with exercise	❒ Difficulty swallowing	❒ Muscle weakness
	❒ Fecal Incontinence	❒ Stiffness
Constitutional	❒ Gas	
❒ Fatigue	❒ Heartburn	**Respiratory**
❒ Fever	❒ Nausea	❒ Asthma
❒ Loss of appetite	❒ Rectal bleeding	❒ Cough
❒ General feeling of being unwell	❒ Stomach cramps	❒ Short of breath
❒ Sweats	❒ Yellow skin or eyes	❒ Excessive sputum
❒ Weight gain	❒ Vomiting	❒ Coughing up blood
❒ Weight loss	**Genitourinary**	❒ Wheezing
	❒ Decrease in urine flow	**Neurological**
ENMT	❒ Painful urination	❒ Dizziness
❒ Ear pain	❒ Frequent urinary infections	❒ Fainting
❒ Loss of vision	❒ Frequent urination	❒ Frequent headaches
❒ Nasal obstruction	❒ Presence of blood in the urine	❒ Migraine
❒ Nose bleeds	❒ Excessive urination at night	❒ Numbness or tingling
❒ Light sensitivity	❒ Urinary incontinence	❒ Seizures
❒ Sore throat		❒ Tremors
❒ Double vision	**Hematologic/ Lymphatic**	❒ Vertigo
	❒ Bleeding gums	
	❒ Swollen lymph nodes	**Psychiatric**
	❒ Easy bruising	❒ Anxiety
	❒ Prolonged bleeding	❒ Depression
We want to inform you that we will be regularly sending you information regarding preventative care and health care reminders. Healthcare procedures such as vaccinations, and diagnoses such as cancer and infectious disease are reported to State and Federal registries, as mandated by law. To insure accuracy, your prescribed medication history may be imported into your medical record from your pharmacy. All of these are allowed and protected by Federal privacy laws.		❒ Hallucinations
		❒ Nervousness
		❒ Panic attacks
		❒ Paranoia
		❒ PTSD

Date: _____ **PLACE PATIENT LABEL HERE**

Patient Signature: _____ **Date**: _____ **Reviewed By**: _____