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 ☐ Unknown ☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander ☐ Mixed ☐ Other ☐ Other Pacific Islander ☐ Patient declines to specify

Ethnicity

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

Gender

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ French ☐ Portuguese ☐ Spanish ☐ Creole ☐ Other: _____

PHARMACY

Name:_____ Phone Number: _____

CURRENT MEDICATIONS

(List all prescription drugs, over the counter medications, and supplements)

☐ None

Name	Dose	How Taken?

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
- ☐ 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: _____

ALLERGIES

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Aspirin
- ☐ Penicillins
- ☐ Codeine Sulfate
- ☐ Sulfa (Sulfonamides)
- ☐ Eggs
- ☐ Latex
- ☐ Iodine/Iodine-Containing Products
- ☐ Soy
- ☐ Morphine
- ☐ 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 Surgery When: _____
- ☐ Fundoplication Surgery When: _____
- ☐ Gallbladder Surgery When: _____
- ☐ Hemorrhoid Surgery When: _____
- ☐ Hysterectomy Surgery When: _____
- ☐ Inguinal Hernia Repair When: _____
- ☐ Ovary Surgery When: _____
- ☐ Prostate When: _____
- ☐ Stomach When: _____
- ☐ Thyroid When: _____
- ☐ Tubal Ligation When: _____
- ☐ Umbilical Hernia Repair When: _____
- ☐ Other _____

FAMILY MEDICAL HISTORY

☐ No knowledge of family history

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

SOCIAL HISTORY

Occupation:_____ Number of Children: _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Alcohol

	Quantity	Number
☐ None		
☐ 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				
☐ Vape/ E Cigarette				

Drug Use

☐ None

☐ 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

EYES
☐ None

Yes	No	
☐	☐	change of vision
☐	☐	eye pain

ENT
☐ None

Yes	No	
☐	☐	hoarseness
☐	☐	mouth sores

ENDOCRINE
☐ None

Yes	No	
☐	☐	cold intolerance

RESPIRATORY
☐ None

Yes	No	
☐	☐	cough
☐	☐	shortness of breath

CARDIOVASCULAR
☐ None

Yes	No	
☐	☐	chest pain
☐	☐	pain in legs when walking
☐	☐	palpitations
☐	☐	swelling of feet/legs

GASTROINTESTINAL
☐ None

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

HEMATOLOGIC/LYMPHATIC
☐ None

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

GENITOURINARY
☐ None

Yes	No	
☐	☐	dark urine

MUSCULOSKELETAL
☐ None

Yes	No	
☐	☐	back pain
☐	☐	joint pain
☐	☐	swollen joints

INTEGUMENTARY
☐ None

Yes	No	
☐	☐	itching
☐	☐	rash
☐	☐	tattoos

NEUROLOGICAL
☐ None

Yes	No	
☐	☐	headaches
☐	☐	numbness/tingling
☐	☐	tremors

PSYCHIATRIC
☐ None

Yes	No	
☐	☐	Memory loss/confusion

IMMUNIZATIONS
☐ None

☐ Flu When: _____

☐ Hepatitis A When: _____

☐ Hepatitis B When: _____

☐ Pneumonia When: _____

☐ HPV When: _____

☐ Shingles When: _____

☐ Tetanus When: _____

☐ Other: When: _____