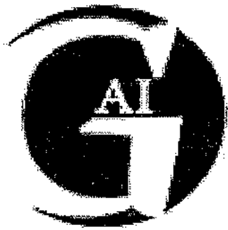

Gastroenterology
Associates, Inc.

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Patient Interview Form

Patient Information

First Name: ______________________ Last Name: ______________________

Date Of Birth: ______________________ Age: ______________________

Email
Please check one as your preferred email for communications

◯ Personal: ______________________ ◯ Work: ______________________

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

Contact Preference

◯ Letter ◯ Email ◯ Patient declines to specify Other: __________

Preferred Language

◯ English ◯ Patient declines to specify Other: __________

Allergies

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

Other: __________

Pharmacy

Name Address Phone

Consent to Import Medication History

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

◯ Yes ◯ No

Printed on 4/22/2014

Current Medications

◯ None

Name	Dose	How taken?

Past or Present Medical Conditions

- None
- Acid Reflux
- Anxiety disorder
- Asthma
- Atrial Fibrillation
- Barrets Esophagus
- Hemophilia
- Ulcerative Colitis
- Colon polyps
- C.O.P.D.
- Crohn's Disease
- Depression
- Diabetes Mellitus
- Diverticulitis
- Elevated cholesterol
- Emphysema
- Glaucoma
- Heart Disease
- History of Hepatitis B
- High blood pressure
- Kidney Disease
- Liver Disease
- Mitral Valve Prolapse/MR
- Hepatitis C
- Pacemaker
- Problems with Anesthesia: Please specify: ______________
- Seizures
- Stroke
- Thyroid disorder
- Tuberculosis
- Cancer: Please Specify type: ______________

Previous Procedures

- None
- Appendectomy When:______________
- Back Surgery When:______________
- Bladder Surgery When:______________
- Cataract surgery When:______________
- Colon Resection When:______________
- D and C When:______________
- Gallbladder removed When:______________
- Hernia Repair When:______________
- Hysterectomy When:______________
- Liver Biopsy When:______________
- Mastectomy Breast: Right/Left/Both When:______________
- Open Heart Surgery- When:______________
- Prostate When:______________
- Tonsillectomy When:______________
- Tubal Ligation When:______________
- Wisdom Teeth Removed When:______________
- Other surgeries not listed: When:______________

Other: ______________

Diagnostic Studies/Tests

- None
- Colonoscopy When:______________
- EGD When:______________

Immunizations

- None
- Pneumonia When:______________
- Flu vaccine When:______________

Social History

Occupation:______________________________ Number of Children:______________________________

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed
- Civil Union
- Unknown
- Other

Caffeine

- None
- Yes Intake:______________________________

Alcohol

- None

Type	Quantity	Number	Frequency
⬭ beer			
⬭ liquor			
⬭ wine			

Exercise

⬭ None

Type	Number
⬭ Yes	

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

Type	Quantity	Frequency

Drug Use

⬭ None

Type	Number
⬭ marijuana	
⬭ other illicit drugs	

Family Medical History

⬭ No knowledge of family history

No family history of ⬭ Colon Cancer ⬭ Colon Polyps

Health Status	Mother	Father	Sister	Brother	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather
Age/Date of Birth	____	____	____	____	____	____	____	____
Alive	O	O	O	O	O	O	O	O
Deceased/At Age	O____	O____	O____	O____	O____	O____	O____	O____
Cause of Death	____	____	____	____	____	____	____	____
Diagnoses								
History of Cancer: type________	O	O	O	O	O	O	O	O
History of Heart Disease (heart attack, heart failure)	O	O	O	O	O	O	O	O
History of Colon Cancer	O	O	O	O	O	O	O	O
History of Strokes	O	O	O	O	O	O	O	O
History of Diabetes	O	O	O	O	O	O	O	O
History of High Blood Pressure	O	O	O	O	O	O	O	O
Other:	O	O	O	O	O	O	O	O

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

⬭ Yes ⬭ No