Gastroenterology Associates, Inc.

Sanjiv Khetarpal. MD, FACG. M.R.C.P. (UK)

4665 Belpar Street, NW / P.O. Box 36329 / Canton, Ohio 44735/ (330) 493-1480 / (330) 493-0105

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

☐ Other Race ☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law ☐ Unknown

Contact Preference

☐ Letter ☐ Email ☐ No Preference ☐ Patient declines to specify Other: _____

Preferred Language

☐ English ☐ Patient declines to specify

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

Food ☐ Peanuts ☐ Shellfish ☐ Eggs ☐ Soy ☐ Dairy Other: _____

Medications ☐ Sulfa (Sulfonamide Antibiotics) ☐ Penicillins Other: _____

Pharmacy

Name Address Phone

Consent to Import Medication History

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

☐ Yes ☐ No

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: _____

☐ Ischemic Vascular Disease (IVD) ☐ Human immunodeficiency virus infection (HIV) ☐ Dementia ☐ Alzheimer ☐ Parkinsons

☐ End-stage renal disease ☐ History of falling ☐ Dependence on wheelchair ☐ Dependence on supplemental oxygen ☐ Nursing home resident

☐ Palliative care patient ☐ Hospice care patient

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:_____
- ◯ Flexible fiberoptic sigmoidoscopy When:_____
- ◯ Fecal Occult Stool Test When:_____

Immunizations

- ◯ None
- ◯ Pneumonia When:_____
- ◯ Flu Shot When:_____
- ◯ SARS-CoV-2 vaccination 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	Quit	Quantity	Frequency
◯ Chewing Tobacco			

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

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

Consent to Share Data

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

☐ Yes ☐ No

Signature

Signature Date

Reminder Preference

I would like to receive preventive care and follow up care reminders.

☐ Yes ☐ No

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present