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GASTRO CARE INSTITUTE

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Patient Interview Form

Patient Information

First Name:________________________ Last Name:________________________

Date of Birth:________________________

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

Sex

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ Spanish; Castilian ☐ Patient declines to specify

Contact Preference

☐ Letter ☐ Email ☐ Patient declines to specify ☐ Other:______________

Pharmacy

Name	Address	Phone

Over

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Adhesive Tape
- ☐ Erythromycin
- ☐ Shellfish
- ☐ Latex Gloves
- ☐ Codeine Sulfate
- ☐ Penicillins
- ☐ IV Dye, Iodine Containing

Current Medications

☐ None

Name	Dose	How taken?

Immunizations

☐ None

☐ Flu vaccine	☐ Hep A	☐ Hep B	☐ Pneumovax	☐ TB skin test
When:__________	When:__________	When:__________	When:__________	When:__________

Diagnostic Studies/Tests

☐ None

☐ Colonoscopy	☐ EGD	☐ CT Abdomen/Pelvis	☐ MRI Abdomen/Pelvis	☐ ERCP
When:__________	When:__________	When:__________	When:__________	When:__________

Previous Procedures

☐ None

- ☐ Gallbladder removed
- ☐ Appendectomy
- ☐ Colon Resection
- ☐ Small Bowel Resection
- ☐ Exploratory Laparoscopy
- ☐ Gastric Bypass
- ☐ Gastric Lap Band
- ☐ Hemorrhoidectomy
- ☐ Hemorrhoid Banding
- ☐ Abdominoplasty
- ☐ Hysterectomy – Abdominal
- ☐ Bilateral Tubal Ligation (BTL)
- ☐ Mastectomy R Breast
- ☐ Pacemaker Insertion
- ☐ Defibrillator Placement
- ☐ Coronary Artery Bypass Graft (CABG)
- ☐ Abdominal Aortic Aneurysm (AAA) Repair
- ☐ Heart Valve Replacement
- ☐ Cardiac Cath – With Stent Placement
- ☐ Joint Replacement
- ☐ Back Surgery
- ☐ Fibromyalgia
- ☐ Other: __________
- ☐ Other: __________

Past or Present Medical Conditions

☐ None

Gastroenterology/ Hepatology

- ☐ Colon Polyp History
- ☐ Colon Cancer
- ☐ Irritable Bowel Syndrome
- ☐ Diverticulitis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Barrett's Esophagus
- ☐ Ulcer Disease
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Fatty Liver
- ☐ Cirrhosis
- ☐ Celiac Disease
- ☐ Bowel Obstruction
- ☐ Pancreatitis
- ☐ Anemia
- ☐ Other: __________
- ☐ Other: __________

Cardiology

- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Atrial Fibrillation
- ☐ Vascular Disease
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Transient Ischemic Attack
- ☐ Valvular Heart Disease
- ☐ Pacemaker
- ☐ Coronary Artery Stents
- ☐ Other: __________
- ☐ Other: __________

Pulmonology

- ☐ C.O.P.D. (Lung)
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Blood Clots (Leg)
- ☐ Wheezing
- ☐ Other: __________
- ☐ Other: __________

Other

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Bipolar Disorder
- ☐ Body Piercings
- ☐ Breast Cancer
- ☐ Current Pregnancy
- ☐ Depression
- ☐ Diabetes Mellitus, Insulin Dependent (Type 1)
- ☐ Diabetes Mellitus, Non-Insulin Dependent (Type 2)
- ☐ Gout
- ☐ Fibrositis/ Fibromyalgia
- ☐ HIV Exposure
- ☐ HIV Infection
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Lung Cancer
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer
- ☐ Seizures
- ☐ Tattoos

Social History

Occupation:____ Number of Children:__________________________________

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Civil Union
- ☐ Unknown
- ☐ Other: __________

Alcohol

- ☐ None
- ☐ Occasionally
- ☐ Daily

Caffeine

- ☐ None
- ☐ Occasionally
- ☐ Daily

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	Started	Quit	Quantity	Frequency
☐ Cigarettes				
☐ Cigar				
☐ Chewing Tobacco				

Drug Use

- ☐ None

Type	Quantity	Number	Frequency
☐ IV or intranasal drugs			Times/month
☐ Recreational			Times/month
☐ Marijuana			Times/month
☐ Heroin			Times/month
☐ Meth			Times/month

Exercise

- ☐ None
- ☐ Regular exercise
- ☐ Occasional exercise

Family Medical History

☐ No knowledge of family history

No family history of ☐ Celiac Sprue ☐ Colon Cancer ☐ Colon Polyps ☐ Crohn's Disease ☐ Liver Disease ☐ Stomach Cancer ☐ Ulcerative Colitis/ IBD

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather
Celiac Disease	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐
Gallbladder Disease	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

Review Of Systems

Allergic/Immunologic

☐ None	Y	N
HIV exposure	☐	☐
Persistent infections	☐	☐
Strong allergic reactions or urticaria	☐	☐

Cardiovascular

☐ None	Y	N
Chest pain	☐	☐
Dyspnea with exercise	☐	☐
Irregular heart beat	☐	☐
Orthopnea	☐	☐
Palpitations	☐	☐
Peripheral edema	☐	☐
Syncope	☐	☐

Constitutional

☐ None	Y	N
Fatigue	☐	☐
Fever	☐	☐
Loss of appetite	☐	☐
Malaise	☐	☐
Sweats	☐	☐
Weight gain	☐	☐
Weight loss	☐	☐

ENMT

☐ None	Y	N
Difficulty swallowing	☐	☐
Dizziness	☐	☐
Ear pain	☐	☐
Nasal obstruction	☐	☐
Nose bleeds	☐	☐
Sore throat	☐	☐
Hearing loss	☐	☐

Endocrine

☐ None	Y	N
Excessive thirst	☐	☐
Hair loss	☐	☐
Heat intolerance	☐	☐

Eyes

☐ None	Y	N
Double vision	☐	☐
Loss of vision	☐	☐
Photophobia	☐	☐

Gastrointestinal

☐ None	Y	N
Abdominal pain	☐	☐
Abdominal swelling	☐	☐
Change in bowel habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Heartburn	☐	☐
Jaundice	☐	☐
Nausea	☐	☐
Rectal bleeding	☐	☐
Stomach cramps	☐	☐
Vomiting	☐	☐
Difficulty swallowing	☐	☐

Genitourinary

☐ None	Y	N
Dark urine	☐	☐
Decrease in urine flow	☐	☐
Dysuria	☐	☐
Frequent urinary infections	☐	☐
Frequent urination	☐	☐
Hematuria	☐	☐
Impotence	☐	☐
Nocturia	☐	☐
Urethral discharge or incontinence	☐	☐

Hematologic/Lymphatic

☐ None	Y	N
Bleeding gums or palpable lymph nodes	☐	☐
Easy bruising	☐	☐
Prolonged bleeding	☐	☐

Integumentary

☐ None	Y	N
Allergies	☐	☐
Dryness	☐	☐
Hives	☐	☐
Itching	☐	☐
Jaundice	☐	☐
Lesions	☐	☐
Rashes	☐	☐

Musculoskeletal

☐ None	Y	N
Arthritis	☐	☐
Back pain	☐	☐
Gout	☐	☐
Joint deformity	☐	☐
Joint pain	☐	☐
Muscle weakness	☐	☐
Stiffness	☐	☐

Neurological

☐ None	Y	N
Dizziness	☐	☐
Fainting	☐	☐
Frequent headaches	☐	☐
Migraine	☐	☐
Numbness or tingling	☐	☐
Seizures	☐	☐
Tremors	☐	☐
Vertigo	☐	☐
Memory loss	☐	☐

Psychiatric

☐ None	Y	N
Anxiety	☐	☐
Depression	☐	☐
Difficulty sleeping	☐	☐
Hallucinations	☐	☐
Nervousness	☐	☐
Panic attacks	☐	☐
Paranoia	☐	☐

Respiratory

☐ None	Y	N
Asthma	☐	☐
Cough	☐	☐
Dyspnea	☐	☐
Excessive sputum	☐	☐
Coughing up blood	☐	☐
Shortness of breath with exercise	☐	☐
Wheezing	☐	☐

Consent to Import Medication History

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

☐ Yes ☐ No

Reminder Preference

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

☐ Yes ☐ No

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

Signature

Signature Date

gciav.com

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