Gastroenterology CONSULTANTS, P.A.
Leaders In Gastrointestinal & Liver Disease

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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____
MRN:_____ Date Of Birth:_____
Age:_____ Notes:_____

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 ☐ Telephone call ☐ E-Mail ☐ Portal Message ☐ Patient declines to specify
Other:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
☐ Civil Union ☐ Unknown ☐ Other

Alcohol

☐ None

Type	Quantity	Number	Frequency
☐ Rarely			
☐ Daily			
☐ More than 2 days per week			
☐ Less than 2 days per week			
☐ I quit consuming alcohol			

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
☐ Chewing Tobacco				

Drug Use

☐ None

☐ Uses illicit drugs ☐ I quit using illicit drugs

Allergies

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

☐ iodine ☐ Latex ☐ Penicillins ☐ Propofol ☐ Tape

☐ Sulfa ☐ Egg Other:_____ Other:_____ Other:_____

Immunizations

☐ None

☐ Hep A, adult When:_____ ☐ Hep B, adult When:_____ ☐ PPD When:_____ ☐ Pneumococcal When:_____

Diagnostic Studies/Tests

☐ None

☐ Abdominal U/S When:_____ ☐ CT Abdomen When:_____ ☐ MRI abdomen When:_____ ☐ Labs When:_____

Past or Present Medical Conditions

☐ None

☐ Anemia When:_____ ☐ Asthma When:_____ ☐ Atrial Fibrillation When:_____ ☐ Personal Hx of Cancer When:_____ ☐ COPD When:_____

☐ Cirrhosis When:_____ ☐ Colitis When:_____ ☐ Colon Cancer When:_____ ☐ Colon Polyps When:_____ ☐ Crohns Disease When:_____

☐ Depression When:_____ ☐ Diabetes T-1 When:_____ ☐ Diabetes T- 2 When:_____ ☐ Diverticulitis When:_____ ☐ Gallstones When:_____

- ☐ GERD When:_____
- ☐ Heart Attack When:_____
- ☐ Hepatitis B When:_____
- ☐ Hepatitis C When:_____
- ☐ Hiatal Hernia When:_____
- ☐ Hypertension When:_____
- ☐ HIV / AIDS When:_____
- ☐ Irritable bowel syndrome (IBS) When:_____
- ☐ Kidney disease When:_____
- ☐ Lactose Intolerance When:_____
- ☐ Pancreatitis When:_____
- ☐ Paralysis When:_____
- ☐ Rheumatoid Arthritis When:_____
- ☐ Seizures When:_____
- ☐ Stomach Ulcer When:_____
- ☐ Sleep Apnea When:_____
- ☐ Stroke When:_____
- ☐ History of TB When:_____
- ☐ PositiveTB Skin Test When:_____
- ☐ Fatty Liver When:_____
- ☐ Kidney Stones When:_____
- ☐ renal failure on dialysis When:_____
- ☐ Home Oxygen When:_____
- Other:_____

Other:_____

Other:_____

Previous Procedures

- ☐ None
- ☐ Appendectomy When:_____
- ☐ CABG When:_____
- ☐ C-Section When:_____
- ☐ Cardiac Surgery When:_____
- ☐ Colon Resection When:_____
- ☐ Colonoscopy When:_____
- ☐ Defibrillator When:_____
- ☐ Pacemaker When:_____
- ☐ EGD/ Upper Endoscopy When:_____
- ☐ ERCP When:_____
- ☐ Gallbladder removed When:_____
- ☐ Hysterectomy (Vaginal) When:_____
- ☐ Liver Biopsy When:_____
- ☐ Obesity / Bariatric Surgery When:_____
- ☐ Transplant Surgery When:_____

Other:_____

Other:_____

Other:_____

Family Medical History

- ☐ No knowledge of family history

No family history of ☐ Colon Cancer ☐ Colon Polyp

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son
Colon Polyps	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○
Pancreas Cancer	○	○	○	○	○	○
Stomach cancer	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○
Crohns Disease	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○

Pharmacy

Name Address Phone

Current Medications

○ None

Name	Dose	How taken?

Consent to Import Medication History

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

○ Yes ○ No

Consent to Share Data

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

○ 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