Bay Area Gastroenterology

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Family Doctor:_____ Referred By:_____

Chief Complaint:_____

For how long:_____

Character of pain: Sharp Dull Burning Aching Other:_____

Location: Lower abdominal Upper abdominal Center Right side Left side

Does pain radiate to any part of the body: Yes No **To:**_____

Frequency:_____ **Duration:**_____

Does pain change with:

Eating:	Worse	Better	No Change
Antacids:	Worse	Better	No Change
Bowel Movements:	Worse	Better	No Change

Does Pain wake you from sleep: Yes No

Heartburn: Yes No Better with treatment Intermittent Progressive

Difficulty swallowing: Yes No Solids Liquids Both

Painful swallowing: Yes No Solids Liquids Both

Any: Nausea Vomiting Excessive Gas Bloating Belching

Appetite: Up Down No Change

Weight: Up Down No Change _____lbs. in _____ days

Bowel movements: Regular Constipation Diarrhea Alternating Frequency:_____

Any blood: Yes No **If yes, is blood mixed with:** Stool Toilet paper only

Bleeding painful: Yes No

Bleeding associated with: Weakness Lightheaded Cramps

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

Sex

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ Spanish; Castilian ☐ Vietnamese ☐ Patient declines to specify Other:_____

Contact Preference

☐ Letter ☐ Cell Phone ☐ Email ☐ Home Phone ☐ All above

☐ Patient declines to specify

Reminder Preference

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

☐ Yes ☐ No

Consent to Share Data

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

☐ Yes ☐ No

Consent to Import Medication History

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

☐ Yes ☐ No

Pharmacy

Name Address Phone

Allergies

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

Other: _____

Current Medications

☐ None

Name	Dose	How taken?

Immunizations

☐ None

☐ Hep B When: _____ ☐ Hep A When: _____ ☐ Flu vaccine When: _____ ☐ TB Screen When: _____ ☐ PCV When: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

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

Alcohol

☐ None

Type	Quantity	Number	Frequency
☐ Beer			
☐ Liquor			
☐ Wine			

Caffeine

☐ None
☐ 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	Started	Quit	Quantity	Frequency
☐ Cigarettes				
☐ Cigar				
☐ Pipe				
☐ Smokeless				

Drug Use

☐ None

Type	Quantity	Number	Frequency

Exercise

☐ None

Type	Quantity	Number	Frequency
☐ Walking			
☐ Cardio			
☐ Running			
☐ Other			

Family Medical History

☐ No knowledge of family history

No family history of

- ☐ Colon cancer
- ☐ Polyps

	Father	Mother	Sister	Brother	Daughter	Son	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Maternal Aunt	Paternal Aunt	Maternal Uncle	Paternal Uncle	First Cousin
Diagnoses															
Hypertension	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Diabetes Mellitus	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Coronary Artery Disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Congestive heart failure	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Rectal Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Colon polyp(s)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Past or Present Medical Conditions

- [ ] None

- [ ] Asthma-Mild When:_____
- [ ] Asthma-Moderate When:_____
- [ ] Asthma-Severe When:_____
- [ ] Congestive heart failure When:_____
- [ ] Coronary artery disease When:_____
- [ ] Mitral valve prolapse When:_____
- [ ] CVA When:_____
- [ ] TIA When:_____
- [ ] Myocardial infarction When:_____
- [ ] Anemia When:_____
- [ ] Iron deficiency Anemia When:_____
- [ ] COPD When:_____
- [ ] Diabetes Mellitus When:_____
- [ ] Gastric ulcer When:_____
- [ ] GERD When:_____
- [ ] Hypercholesterolemia When:_____
- [ ] Hypertension When:_____
- [ ] Hyperthyroidism When:_____
- [ ] Hypothyroidism When:_____
- [ ] Renal failure When:_____
- [ ] Migraines When:_____
- [ ] Neuropathy When:_____
- [ ] Osteoporosis When:_____
- [ ] Pneumonia When:_____
- [ ] Rheumatic Fever When:_____
- [ ] Rheumatoid arthritis When:_____
- [ ] Arthritis When:_____
- [ ] Seizures When:_____
- [ ] Sleep apnea When:_____
- [ ] Alzheimer's disease When:_____
- [ ] Dementia When:_____
- [ ] Depression When:_____
- [ ] Anxiety When:_____
- [ ] Deep vein thrombosis When:_____
- [ ] Diverticulosis When:_____
- [ ] Fatty liver-NAFLD When:_____
- [ ] Crohn's Disease When:_____
- [ ] Colon polyps When:_____
- [ ] Cirrhosis When:_____
- [ ] Hepatitis B Virus When:_____
- [ ] Hepatitis A Virus When:_____
- [ ] Hepatitis C Virus When:_____
- [ ] Ulcerative colitis When:_____

Other:_____

Diagnostic Studies/Tests

- [ ] None

- [ ] Colonoscopy When:_____
- [ ] EGD When:_____
- [ ] Flexsigmoidoscopy When:_____
- [ ] Bone density When:_____
- [ ] Mammogram When:_____

Previous Procedures

- [ ] None

- [ ] Hernia Repair When:_____
- [ ] Tonsillectomy When:_____
- [ ] Appendectomy When:_____
- [ ] Hip Replacement When:_____
- [ ] Bunionectomy When:_____
- [ ] Vasectomy When:_____
- [ ] Tubal Ligation When:_____
- [ ] C-Section When:_____
- [ ] D and C When:_____
- [ ] Exploratory Laparotomy/Laparoscopy When:_____
- [ ] Colon Resection When:_____
- [ ] Hemorrhoidectomy When:_____
- [ ] Gastric Band When:_____
- [ ] Gastric By-Pass When:_____
- [ ] Lithotripsy When:_____
- [ ] CABG When:_____
- [ ] Pacemaker When:_____
- [ ] Open Heart Surgery- When:_____
- [ ] Hysterectomy When:_____
- [ ] Back Surgery When:_____
- [ ] Knee replacement When:_____
- [ ] Laparoscopic Cholecystectomy When:_____
- [ ] Open Cholecystectomy When:_____
- [ ] Foot Surgery When:_____
- [ ] Prostate surgery When:_____
- [ ] Breast surgery When:_____
- [ ] Shoulder Surgery When:_____
- [ ] Carpal Tunnel surgery When:_____
- [ ] Transplant When:_____
- [ ] PTCA When:_____

Other:_____

Review Of Systems

Cardiovascular

None	Y	N
chest pain	○	○
irregular heart beat	○	○
peripheral edema	○	○

ENMT

None	Y	N
ear pain	○	○
nose bleeds	○	○
sore throat	○	○
hearing loss	○	○
hoarsness	○	○
sinus	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○
chills	○	○

Endocrine

None	Y	N
excessive thirst	○	○
excessive urination	○	○

Eyes

None	Y	N
double vision	○	○
loss of vision	○	○
blurring vision	○	○

Genitourinary

None	Y	N
decrease in urine flow	○	○
frequent urinary infections	○	○
frequent urination	○	○
nocturia	○	○
menses	○	○

Hematologic/Lymphatic

None	Y	N
easy bruising	○	○
prolonged bleeding	○	○
palpable lymph nodes	○	○

Integumentary

None	Y	N
allergies	○	○
rashes	○	○

Musculoskeletal

None	Y	N
back pain	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
nervousness	○	○

Respiratory

None	Y	N
asthma	○	○
cough	○	○
shortness of breath with exercise	○	○
wheezing	○	○

Reviewed with

○ Patient ○ Parent ○ Guardian ○ Not Present

Signature

Signature Date