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COLUMBIA GASTROENTEROLOGY ASSOCIATES, P.A.

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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 ☐ Unknown

Preferred Language

☐ English ☐ Spanish; Castilian ☐ Patient declines to specify

Contact Preference

☐ Letter ☐ Email ☐ Phone ☐ Patient declines to specify Other: _____

Pharmacy

Name Address Phone

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Adhesive Tape
- ☐ Codeine Sulfate
- ☐ Erythromycin
- ☐ Penicillins
- ☐ Shellfish
- ☐ Iv Dye, Iodine Containing
- ☐ Latex gloves
- ☐ aspirin
- ☐ morphine
- ☐ Neosporin
- ☐ Sulfa Drugs

Current Medications

- ☐ None

Name	Dose	How taken?

Immunizations

- ☐ None
- ☐ Flu vaccine When:
- ☐ Hep A When:
- ☐ Hep B When:
- ☐ Pneumovax When:
- ☐ TB skin test When:

Diagnostic Studies/Tests

- ☐ None
- ☐ Colonoscopy When:
- ☐ EGD When:
- ☐ CT Abdomen/Pelvis When:
- ☐ MRI Abdomen/Pelvis When:
- ☐ ERCP When:
- ☐ Abdominal Ultrasound When:

Previous Procedures

- ☐ None
- ☐ Gallbladder removed When:
- ☐ Appendectomy When:
- ☐ Colon resection When:
- ☐ Small Bowel Resection When:
- ☐ Exploratory Laparoscopy When:
- ☐ Gastric Bypass When:
- ☐ Gastric Lap Band When:
- ☐ Hemorrhoidectomy When:
- ☐ Hemorrhoid banding When:
- ☐ Abdominoplasty When:
- ☐ Hysterectomy - Abdominal When:
- ☐ Bilateral Tubal Ligation (BTL) When:
- ☐ Pacemaker Insertion When:
- ☐ Defibrillator Placement When:
- ☐ Coronary Artery Bypass Graft (CABG) When:
- ☐ Abdominal aortic aneurysm (AAA) repair When:
- ☐ Heart valve replacement When:
- ☐ Cardiac Cath - with stent placement When:
- ☐ Joint Replacement When:
- ☐ Back Surgery When:

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.
☐ Asthma
☐ Sleep apnea
☐ Blood Clots (leg)
☐ Blood Clots (lung)
☐ 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
☐ HIV exposure
☐ HIV infection
☐ Hypothyroidism
☐ Kidney disease
☐ Kidney stones
☐ Lung cancer
☐ Ovarian Cancer
☐ Prostate Cancer
☐ Skin Cancer
☐ Seizures
☐ Tattoos
☐ Obesity

Social History

Occupation: _____ Number of Children: _____

Marital Status

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

Alcohol

☐ None

Type

☐ Occasionally
☐ Daily

Quantity Number Frequency

_____

_____

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

Exercise

None

Type	Quantity	Number	Frequency
Regular exercise			
Occasional exercise			

Family Medical History

☐ No knowledge of family history

No family history of

☐ Adopted
☐ Colon cancer
☐ Crohn's disease
☐ Stomach cancer
☐ Celiac sprue
☐ Colon polyps
☐ Liver disease
☐ Ulcerative Colitis / IBD

	Mother	Father	Sister	Brother	Grandmother	Grandfather
Health Status						
Age/Date of Birth	_____	_____	_____	_____	_____	_____
Healthy	○	○	○	○	○	○
Ill	○	○	○	○	○	○
Seriously Ill	○	○	○	○	○	○
Disabled	○	○	○	○	○	○
In Remission	○	○	○	○	○	○
Alive	○	○	○	○	○	○
Deceased/At Age	○____	○____	○____	○____	○____	○____
Cause of Death	_____	_____	_____	_____	_____	_____
Diagnoses						
Celiac Disease	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○
Stomach cancer	○	○	○	○	○	○
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	○	○

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	○	○

change in bowel habits	○○
constipation	○○
diarrhea	○○
gas	○○
heartburn	○○
jaundice	○○
nausea	○○
rectal bleeding	○○
stomach cramps	○○
vomiting	○○
difficulty swallowing	○○

Consent to Import Medication History

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

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.

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.

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

○ Yes ○ No

Reviewed with

○ Patient ○ Parent ○ Guardian ○ Not Present

Signature

Signature Date