Gastroenterology HEALTH PARTNERS

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Past or Present Medical Conditions

☐ None

GI-Related:	☐ Cirrhosis	☐ Colon Polyps	☐ Crohn's Disease	☐ Diverticulitis
	☐ Esophagitis/GERD	☐ Gallstones	☐ Hepatitis	☐ Irritable Bowel Syndrome
	☐ Pancreatitis	☐ Stomach Ulcer	☐ Ulcerative Colitis	☐ Barrett's Esophagus
	☐ C-diff	☐ Colon cancer	☐ Hiatal hernia	☐ Hemorrhoids
	☐ H. Pylori positive	☐ Liver Disease		
General:	☐ Abnormal Blood Clotting/Blood Clots	☐ Anemia	☐ Arterial Blockages	☐ Ascites
	☐ Asthma	☐ Atrial Fibrillation	☐ Back pain	☐ Blood Transfusion
	☐ Brain Injury/Tumor	☐ Cancer	☐ COPD	☐ Depression
	☐ Diabetes Mellitus	☐ Emphysema	☐ Endometriosis	☐ Fibromyalgia
	☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol	☐ HIV/AIDS
	☐ Irregular Heart Beat	☐ Kidney Disease/Failure	☐ Kidney Stones	☐ Lupus
	☐ Multiple Sclerosis	☐ Osteoporosis	☐ Parkinsons	☐ Psoriasis
	☐ Rheumatic Fever	☐ Seizures	☐ Sexually transmitted infectious disease	☐ Sleep Apnea
	☐ Stroke or Paralysis	☐ TB or Positive TB Skin Test	☐ Thyroid Disease	☐ Currently Pregnant

Other:_____

Previous Procedures

- [ ] None

- [ ] Capsule Endoscopy
- [ ] Cholecystectomy (Gallbladder)
- [ ] Colon Polyp Removal
- [ ] Colon Resection
- [ ] Colon Surgery
- [ ] Hemorrhoid
- [ ] Hiatal Hernia
- [ ] Liver Biopsy
- [ ] Stomach Surgery
- [ ] Appendectomy
- [ ] Heart Stent Placement
- [ ] Cardiac (CABG)
- [ ] Artificial Heart Valve
- [ ] Pacemaker
- [ ] Debifrillator
- [ ] Prostate Surgery
- [ ] Hysterectomy
- [ ] Ovary Surgery
- [ ] C-Section
- [ ] Mastectomy
- [ ] Radiation Therapy
- [ ] Thyroid Surgery
- [ ] Kidney Surgery
- [ ] Joint Replacement
- [ ] back surgery
- [ ] Bladder Surgery
- [ ] Breast Surgery
- [ ] Cosmetic Surgery
- [ ] Kidney Dialysis
- [ ] ERCP/Stent & Stone Extraction
- [ ] Obesity Surgery
- [ ] Tubal Ligation

Other: _____

Diagnostic Studies/Tests

- [ ] None

- [ ] Colonoscopy — When: _____
- [ ] EGD — When: _____
- [ ] CT Scan — When: _____
- [ ] Ultrasound — When: _____
- [ ] MRI — When: _____
- [ ] Chest X-Ray — When: _____
- [ ] Gastric Emptying Study — When: _____
- [ ] ERCP — When: _____
- [ ] HIDA Scan (Gallbladder) — When: _____
- [ ] X-Ray - Abdomen — When: _____

Other: _____

Allergies

- [ ] Patient has no known allergies
- [ ] Patient has no known drug allergies

- [ ] Latex Gloves, Large
- [ ] Iodine And Iodide Containing Products
- [ ] Sulfa (Sulfonamide Antibiotics)
- [ ] Penicillins
- [ ] Contrast/Dye used in X-ray Studies
- [ ] aspirin
- [ ] codeine sulfate
- [ ] Lidocaine
- [ ] morphine
- [ ] Narcotics
- [ ] Nsaids (Non-Steroidal Anti-Inflammatory Drug)
- [ ] Propofol
- [ ] Eggs
- [ ] Peanuts
- [ ] SOY

Please list allergies and describe reaction:

Other: _____ Other: _____ Other: _____

Immunizations

- [ ] None

- [ ] Flu Vaccine — When: _____
- [ ] Pneumonia Vaccine — When: _____
- [ ] Hepatitis A — When: _____
- [ ] Hepatitis B — When: _____
- [ ] Tetanus, Diphtheria & Pertussis — When: _____
- [ ] PPD/TB test — When: _____
- [ ] Shingles — When: _____
- [ ] HPV — When: _____
- [ ] Tetanus Toxoid — When: _____
- [ ] Meningococcal — When: _____

Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

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

Alcohol

- ☐ None
- ☐ Social (Few drinks per month)
- ☐ Light (Few drinks per week)
- ☐ Moderate (1 drink daily)
- ☐ Heavy (Multiple drinks 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

Drug Use

- ☐ None

Type Frequency

_____

_____

Exercise

- ☐ None
- ☐ 1-2 Times per Week
- ☐ 3-5 Times per Week
- ☐ 1-2 Times per Month

Type:_____

Family Medical History

☐ No knowledge of family history

No family history of

- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ Gastric Cancer
- ☐ GI Cancer
- ☐ Liver Disease
- ☐ Pancreatic Cancer
- ☐ Pancreatitis
- ☐ Stomach Cancer
- ☐ Ulcerative Colitis

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Other
Breast Cancer	○	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○	○
Lynch Syndrome	○	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○	○
Pancreatitis	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○
Uterine Cancer	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○

Pharmacy

Name Address Phone

Current Medications

☐ None

Name	Dose	How taken?

Review Of Systems

Allergic/Immunologic

None	Y	N
persistent infections	○	○
HIV exposure	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

None	Y	N
ankle swelling	○	○
chest pain	○	○
irregular heart beat	○	○
shortness of breath	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
weight loss	○	○
weight gain	○	○

ENMT

None	Y	N
hearing loss	○	○
hoarseness	○	○
sore throat	○	○
nose bleeds	○	○

Endocrine

None	Y	N
excessive thirst	○	○
cold intolerance	○	○
heat intolerance	○	○

Eyes

None	Y	N
light sensitivity	○	○
eye pain	○	○
visual decline	○	○

Gastrointestinal

None	Y	N
abdominal pain	○	○
belching	○	○
black stools	○	○
bloating	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
difficulty swallowing	○	○
painful swallowing	○	○
flatulence/rectal gas	○	○
heartburn/reflux	○	○
mucous in stools	○	○
nausea	○	○
painful stools	○	○
rectal bleeding	○	○
rectal protusions	○	○
rectal urgency	○	○
soiling/incontinence	○	○
vomiting	○	○
vomiting with blood	○	○

Genitourinary

None	Y	N
blood in urine	○	○
burning urination	○	○

Hematologic/Lymphatic

None	Y	N
easy bruising	○	○
prolonged bleeding	○	○
abnormal blood clotting	○	○

Integumentary

None	Y	N
itching	○	○
jaundice	○	○
rash	○	○
suspicious lesions	○	○

Musculoskeletal

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

Neurological

None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
loss of consciousness	○	○

Psychiatric

None	Y	N
anxiety/panic	○	○
depression	○	○
difficulty sleeping	○	○

Respiratory

None	Y	N
coughing blood	○	○
chronic cough	○	○
painful breathing	○	○

Reminder Preference

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

Yes No

Reviewed with

Patient Parent Guardian Not Present

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

Signature

Signature Date