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ADVANCED GASTROINTESTINAL SPECIALISTS, P.C.
Leading the way in experienced, compassionate & multidimensional care

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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

◯ Unknown ◯ Patient declines to specify

Ethnicity

◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Patient declines to specify

Sex

◯ Male ◯ Female ◯ Other

Preferred Language

◯ Chinese ◯ English ◯ Greek, Modern (1453-) ◯ Hebrew ◯ Hindi

◯ Russian ◯ Spanish; Castilian ◯ Vietnamese ◯ Patient declines to specify Other:_____

Contact Preference

◯ Home ◯ Cell ◯ Work ◯ Any ◯ Email

◯ Patient declines to specify Other:_____

Allergies

◯ Patient has no known allergies ◯ Patient has no known drug allergies

◯ Latex ◯ Eggs ◯ Penicillins ◯ Iodine-Iodine Containing ◯ Ketamine

- ◯ Sulfa (Sulfonamide Antibiotics)
- ◯ Other
- ◯ Nsaids (Non-Steroidal Anti-Inflammatory Drug)

Current Medications

◯ None

Name	Dose	How taken?

Immunizations

◯ None

- ◯ Hep B — When: _____
- ◯ Hep A — When: _____
- ◯ Pneumonia Vaccine — When: _____
- ◯ Flu Vaccine — When: _____

Diagnostic Studies/Tests

◯ None

- ◯ Colonoscopy — When: _____
- ◯ Upper Endoscopy — When: _____
- ◯ Medical Imaging (CT Scan, MRI, Ultrasound) — When: _____
- Other: _____

Past or Present Medical Conditions

◯ None

Neurologic	◯ Seizures	◯ Stroke/Mini-Stroke	◯ Neuropathy	◯ Migraines
	◯ Vertigo	◯ Syncope	◯ Burning Tongue Syndrome	◯ Multiple sclerosis
Cardiovascular	◯ Acute MI (heart attack)	◯ Angina	◯ Atrial Fibrillation	◯ Hypertension
	◯ Carotid artery disease	◯ Congestive Heart Failure	◯ Heart Valve Replacement	
Pulmonary	◯ C.O.P.D.	◯ Asthma	◯ Sleep apnea	◯ Oxygen use
GI	◯ GERD	◯ Colon Cancer	◯ Colon polyps	◯ Diverticulitis
	◯ Gallstones	◯ Hepatitis	◯ Irritable Bowel Syndrome	◯ Cirrhosis
	◯ Stomach cancer	◯ Ulcerative Colitis	◯ Crohn's Disease	◯ Acute pancreatitis
	◯ Chronic pancreatitis	◯ Microscopic (collagenous/lymphocytic) colitis		
GU	◯ Chronic Kidney Disease	◯ On Dialysis	◯ Kidney Stones	◯ Kidney transplant
Psych	◯ Anxiety Disorder	◯ Depression	◯ Bipolar Disorder	
Endocrine	◯ Hypothyroidism	◯ Hypercholesterolemia	◯ Hypertriglyceridemia	◯ Hyperthyroidism
	◯ Sjogren's Syndrome	◯ Hypoglycemia	◯ Diabetes Mellitus (on insulin)	◯ Diabetes Mellitus (NOT on insulin)
	◯ Osteoporosis	◯ Osteopenia		
Heme/Onc	◯ Bleeding Disorder	◯ Cancer	◯ Anemia	

Miscellaneous

- ◯ Arthritis
- ◯ Glaucoma
- ◯ Organ Transplant
- ◯ Other
- ◯ Cataracts

Previous Procedures

◯ None

Abdominal Surgeries

- ◯ Appendectomy — When: _____
- ◯ Bladder Surgery — When: _____
- ◯ C-Section — When: _____
- ◯ Gallbladder removed (cholecystectomy) — When: _____
- ◯ Colon Resection — When: _____
- ◯ Hysterectomy — When: _____
- ◯ Hernia Repair — When: _____
- ◯ Gastric By-Pass — When: _____
- ◯ Gynecologic Surgery — When: _____
- ◯ Gastric resection — When: _____
- ◯ Lap Band for morbid obesity — When: _____
- ◯ Lysis of Adhesions — When: _____
- ◯ Tubal Ligation — When: _____

Heart/Lung Surgeries

- ◯ Heart Valve Replacement — When: _____
- ◯ Heart Stent — When: _____
- ◯ Open Heart/Bypass — When: _____
- ◯ Cardiac Catheterization — When: _____
- ◯ Angioplasty — When: _____
- ◯ Carotid Stent — When: _____
- ◯ Vascular surgery — When: _____
- ◯ Pacemaker/defibrillator — When: _____

Orthopedic

- ◯ Knee Replacement — When: _____
- ◯ Hip Replacement — When: _____
- ◯ Carpal Tunnel — When: _____
- ◯ Shoulder surgery — When: _____
- ◯ Spinal Surgery — When: _____
- ◯ Arthroscopy — When: _____

Other Surgeries

- ◯ Breast Lumpectomy — When: _____
- ◯ Other Surgery — When: _____
- ◯ Cataract surgery — When: _____
- ◯ Prostatectomy — When: _____
- ◯ Wisdom teeth — When: _____
- ◯ TURP — When: _____
- ◯ Tonsillectomy — When: _____

Social History

Occupation: _____

Marital Status

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Separated
- ◯ Widowed

Alcohol

- ◯ None
- ◯ Less than 5 per week
- ◯ 5 to 10 per week
- ◯ Greater than 10 per week
- ◯ rarely

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				

Caffeine

- ◯ None
- ◯ 2 or less cups coffee/tea per day
- ◯ More than 2 cups coffee/tea per day
- ◯ More than 3 sodas per day
- ◯ Decaffeinated coffee/tea

Drug Use

- ◯ None
- ◯ Current IV Drug Use
- ◯ Past IV Drug Use
- ◯ Recreational Drug Use
- ◯ Marijuana
- ◯ Cocaine

Exercise

- ◯ None

Type Number Frequency

Family Medical History

- ◯ No knowledge of family history

No family history of

- ◯ Colon Cancer
- ◯ Colon Polyps

	Mother	Father	Sister	Brother	Grandmother	Grandfather	Daughter	Son
Diagnoses								
Colonic Polyps	◯	◯	◯	◯	◯	◯	◯	◯
Colon Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Crohns Disease	◯	◯	◯	◯	◯	◯	◯	◯
Stomach Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Cirrhosis	◯	◯	◯	◯	◯	◯	◯	◯
Celiac Disease	◯	◯	◯	◯	◯	◯	◯	◯
Ulcerative Colitis	◯	◯	◯	◯	◯	◯	◯	◯
Peptic Ulcer Disease	◯	◯	◯	◯	◯	◯	◯	◯
Gallstones	◯	◯	◯	◯	◯	◯	◯	◯
Pancreatic Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Liver Disease	◯	◯	◯	◯	◯	◯	◯	◯
Breast Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Cervical Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Ovarian Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Uterine Cancer	◯	◯	◯	◯	◯	◯	◯	◯

Review Of Systems

Cardiovascular

◯ None	Y	N
chest pain or pressure	◯	◯
fluttering heart	◯	◯
leg swelling	◯	◯

Constitutional

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

ENMT

◯ None	Y	N
nose bleeds	◯	◯
hearing loss	◯	◯

Endocrine

◯ None	Y	N
excessive thirst	◯	◯
heat intolerance	◯	◯

Eyes

◯ None	Y	N
double/blurred vision	◯	◯
loss of vision	◯	◯

Gastrointestinal

◯ None	Y	N
abdominal pain	◯	◯
abdominal swelling/bloat	◯	◯
change in bowel habits	◯	◯
constipation	◯	◯
diarrhea	◯	◯
excess gas	◯	◯
heartburn	◯	◯
belching/burping	◯	◯
yellow skin or eyes	◯	◯
nausea	◯	◯
vomiting	◯	◯
stomach cramps	◯	◯
blood in stool	◯	◯
difficulty swallowing	◯	◯

Genitourinary

◯ None	Y	N
dark urine	◯	◯
painful urination	◯	◯
frequent urination	◯	◯
blood in urine	◯	◯
no periods	◯	◯
heavy periods	◯	◯

Hematologic/Lymphatic

◯ None	Y	N
easy bruising	◯	◯
prolonged bleeding	◯	◯

Integumentary

◯ None	Y	N
itching	◯	◯
rashes	◯	◯

Musculoskeletal

◯ None	Y	N
back pain	◯	◯
joint pain	◯	◯
muscle weakness	◯	◯

Neurological

◯ None	Y	N
dizziness	◯	◯
fainting	◯	◯
frequent headaches	◯	◯
numbness or tingling	◯	◯

Psychiatric

◯ None	Y	N
anxiety	◯	◯
depression	◯	◯

Respiratory

◯ None	Y	N
cough	◯	◯
shortness of breath	◯	◯
wheezing	◯	◯

Pharmacy

Name Address Phone

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

Reviewed with

Patient Parent Guardian Not Present