Patient Interview Form

GASTROENTEROLOGY ASSOCIATES

Patient Information

First Name:_____ **Middle Initial:**_____ **Last Name**: _____

Date of Birth:_____ **Age**:_____ **Occupation**:_____

REASON FOR VISIT:_____

Allergies and Reactions

⬭ No known drug allergies

Allergy:	**Reaction:**

Current Medications, including over-the-counter:

⬭ None

Name of medication:	Dose:	How Often:

Medical Conditions:

⬭	⬭
⬭	⬭
⬭	⬭
⬭	⬭
⬭	⬭
⬭	⬭

Diagnostic Studies/Tests:

⬭ None

⬭ Colonoscopy When:_____

⬭ Upper Endoscopy When:_____

⬭ ERCP When:_____

⬭ Flexible Sigmoidoscopy When:_____

⬭ Capsule Endoscopy When:_____

⬭ CT When:_____

⬭ MRI When:_____

⬭ Ultrasound When:_____

⬭ Pacemaker When:_____

⬭ Defibrillator When:_____

Previous Surgeries/Procedures: ⬭ None

⬭	⬭
⬭	⬭
⬭	⬭
⬭	⬭

Immunizations: ⬭ None ⬭ Flu Vaccine, Date: _____ ⬭ Pneumonia, Date: _____

Alcohol: Do you drink alcohol? ⬭ No ⬭ Yes

*If yes, do you drink 7 or more glasses of alcohol in 7 days? ⬭ No ⬭ Yes

Tobacco: ⬭ Never ⬭ Current tobacco use ⬭ Former tobacco use

Started: _____ Quantity: _____ How Often: _____ Quit: _____

Opioids/Narcotics: Name of Medication(s): _____ How Often: _____

Marijuana: ⬭ Never ⬭ Current ⬭ Former

Started: _____ Quantity: _____ How Often: _____ Quit: _____

Recreational Drug Use: ⬭ Never ⬭ Current ⬭ Former ⬭ IV Drugs ⬭ Other:_____

Review of Systems - In the last *2 Months* have you had any of the following:

Constitutional	**Yes**	**No**
Fever	O	O
Weight loss	O	O
Weight gain	O	O
Gastrointestinal		
Abdominal pain	O	O
Abdominal swelling	O	O
Change in bowel habits	O	O
Constipation	O	O
	Yes	**No**
Diarrhea	O	O
Gas	O	O
Heartburn	O	O
Jaundice	O	O
Nausea	O	O
Rectal bleeding	O	O
Stomach cramps	O	O
Vomiting	O	O
Black or bright red blood in stool	O	O
Difficulty swallowing	O	O

Does anyone in your family have a history of the following:

☐ No knowledge of family history

Family History Of:	If Yes, which family member:	Age at diagnosis:
⬭ Colon Cancer		
⬭ Colon Polyps		
⬭ Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis		
⬭ Pancreatic Cancer		

_____ _____ _____ _____

Patient Signature Date Provider Initials Date

_____ _____

Patient or Legally Authorized Representative Signature Relationship to Patient