Patient Interview Form

OhioGastro
Ohio Gastroenterology Group, Inc.

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

- ☐ English
- ☐ French
- ☐ Japanese
- ☐ Russian
- ☐ Patient declines to specify

Pharmacy

Name	Address	Phone

Allergies

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

- ☐ Codeine Sulfate
- ☐ Penicillins
- ☐ Demerol
- ☐ Latex
- ☐ Adhesive Tape
- ☐ Versed
- ☐ Aspirin (Tartrazine Only)
- ☐ Propofol
- ☐ Iodinated Contrast Media - IV Dye
- ☐ Fentanyl Citrate
- ☐ Morphine (bulk)

Other: __________ Other: __________ Other: __________

Current Medications

- ☐ None

Name	Dose

Immunizations

- ☐ None
- ☐ DTaP/Tetanus When:________
- ☐ Hep A When:________
- ☐ Hep B When:________
- ☐ Influenza When:________
- ☐ Pneumonia When:________
- ☐ PPD When:________
- ☐ Measles/Mumps When:________
- ☐ Varicella/Chicken Pox When:________
- Other:________
- Other:________

Diagnostic Studies/Tests

- ☐ None
- ☐ EGD When:________
- ☐ Colonoscopy When:________
- ☐ CT Abdomen When:________
- ☐ Abdominal Ultrasound When:________
- ☐ MRI Abdomen When:________
- Other:________

Previous Procedures

- ☐ None
- ☐ Automatic Defibrillator Placement
- ☐ Colon/Bowel Surgery
- ☐ Gallbladder
- ☐ Stomach Surgery
- ☐ Heart Bypass
- ☐ Heart Stent
- ☐ Heart Valve
- ☐ Hemorrhoids
- ☐ Hysterectomy
- ☐ Pacemaker Insertion
- ☐ Reflux Surgery
- ☐ Obesity Surgery
- Other:________
- Other:________
- Other:________

Past or Present Medical Conditions

- ☐ None
- ☐ Anesthesia complication
- ☐ Acid Reflux
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding/Clotting Disorder
- ☐ Cancer
- ☐ Chronic Lung Disease
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ Depression/ Anxiety
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Endocarditis (Heart Valve Infection)
- ☐ Fatty Liver
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hiatal Hernia
- ☐ Heart Murmur
- ☐ High blood pressure
- ☐ History of Suicide Attempts
- ☐ HIV/AIDS
- ☐ Irregular Heart Beat
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Neck or Jaw Injury
- ☐ Osteoarthritis
- ☐ Pancreatitis
- ☐ Parkinsons
- ☐ Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Skin Cancer
- ☐ Sleep Apnea/ CPAP
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ TB (Tuberculosis)
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis
- Other:________
- Other:________
- Other:________
- Other:________

Family Medical History

- ☐ No knowledge of family history

No family history of ☐ Colon Cancer ☐ No family History of Colon Polyps

Diagnoses	Father	Mother	Brother	Sister	Grandfather	Grandmother	Other
Crohn's	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○
Gall Bladder Disease	○	○	○	○	○	○	○
Heart Trouble	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○
Pancreatitis	○	○	○	○	○	○	○
Ulcer	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○	○
Pancreas Cancer	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○

Social History

Occupation:______________________ Number of Children:______________________

Marital Status

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

Alcohol

☐ None

Type Quantity Number Frequency

____

Caffeine

☐ None

Intake:______________________

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 Quantity Number Frequency

____

Height __________ Weight __________

Exercise

☐ None

Type:______________________ Type:______________________

- ☐ Ambulates Independently
- ☐ Walks with Cane
- ☐ Walks with Walker
- ☐ Uses Wheelchair
- ☐ Requires Transport or Ambulance

Review Of Systems

Allergic/Immunologic (Yes / No)
- [ ] None
- HIV exposure
- persistent infections
- strong allergic reactions or urticaria

Cardiovascular (Yes / No)
- [ ] None
- chest pain
- shortness of breath with exercise
- irregular heart beat
- leg or ankle swelling
- shortness of breath with lying down
- fast or irregular heart beating
- shortness of breath
- fainting or passing out

Constitutional (Yes / No)
- [ ] None
- fatigue
- fever
- loss of appetite
- malaise
- sweats
- night sweats
- weight gain
- weight loss

ENMT (Yes / No)
- [ ] None
- difficulty swallowing
- dizziness
- ear pain
- nasal obstruction
- nose bleeds
- sore throat
- hearing loss

Endocrine (Yes / No)
- [ ] None
- cold intolerance
- excessive thirst
- hair loss
- heat intolerance

Eyes (Yes / No)
- [ ] None
- blurred vision
- double vision
- dry eyes
- loss of vision
- eye pain with bright light
- red eyes

Gastrointestinal (Yes / No)
- [ ] None
- abdominal pain
- abdominal swelling
- change in bowel habits
- constipation
- dairy intolerance
- diarrhea
- difficulty swallowing
- gas
- heartburn
- loss of bowel control
- jaundice
- nausea
- stomach cramps
- rectal bleeding
- rectal Pain
- vomiting

Genitourinary (Yes / No)
- [ ] None
- dark urine
- decrease in urine flow
- dysuria
- frequent urinary infections
- frequent urination
- blood in the urine
- impotence
- frequent night time urination
- uretheral discharge
- urinary leakage or accidents

Hematologic/Lymphatic (Yes / No)
- [ ] None
- bleeding gums
- easy bruising
- swollen lymph nodes
- prolonged bleeding

Integumentary (Yes / No)
- [ ] None
- allergies
- dryness
- hives
- itching
- jaundice
- lesions
- rashes

Musculoskeletal (Yes / No)
- [ ] None
- arthritis
- back pain
- gout
- joint deformity
- joint pain
- muscle weakness
- stiffness

Neurological (Yes / No)
- [ ] None
- dizziness
- fainting
- frequent headaches
- migraine
- numbness or tingling
- recent fall
- seizures
- tremors
- vertigo
- memory loss

Psychiatric (Yes / No)
- [ ] None
- anxiety
- depression
- difficulty sleeping
- hallucinations
- nervousness
- panic attacks
- paranoia

Respiratory (Yes / No)
- [ ] None
- asthma
- cough
- dyspnea
- excessive sputum
- coughing up blood
- shortness of breath with exercise
- wheezing

Reviewed with

- [ ] Patient
- [ ] Parent
- [ ] Guardian
- [ ] Not Present

Signature

Signature ______________________ Date ______________________