NEW YORK GASTROENTEROLOGY ASSOCIATES

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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: _____

Contact Preference

☐ Cell phone ☐ Email address: ☐ Please, Provide Email address: _____ ☐ Patient declines to specify

☐ Home Phone _____ ☐ Patient declines to specify

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

Preferred Language

☐ English ☐ Patient declines to specify

Allergies

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

☐ Latex ☐ Penicillins ☐ Soy ☐ Eggs ☐ aspirin

☐ codeine-guaifenesin ☐ morphine ☐ Sulfa (Sulfonamide Antibiotics) ☐ erythromycin ☐ Iodine-Iodine Containing

☐ Demerol (PF)

Current Medications

☐ None

Name	Dose	How taken?

Pharmacy

Name Address Phone

Immunizations

- ◯ None
- ◯ Flu Vaccine When:_____
- ◯ Pneumonia vaccine When:_____

Diagnostic Studies/Tests

- ◯ None
- ◯ Colonoscopy When:_____
- ◯ Endoscopy When:_____
- ◯ CT Abdomen/Pelvis, Chest When:_____
- ◯ Abdominal U/S When:_____

Past or Present Medical Conditions

- ◯ None

Heart Disease:

- ◯ Heart valve replacement When:_____
- ◯ Heart Valve Stent When:_____
- ◯ Defibrillator When:_____
- ◯ Pacemaker When:_____
- ◯ Atrial Fibrilation When:_____
- ◯ Aortic Stenosis When:_____
- ◯ History of a heart attack (MI) When:_____
- ◯ Bleeding Tendencies When:_____

Lung Disease:

- ◯ C.O.P.D. When:_____
- ◯ Asthma When:_____
- ◯ Home oxygen use When:_____
- ◯ Sleep apnea When:_____

Other Medical Conditions:

- ◯ Diabetes Mellitus When:_____
- ◯ Hypertension When:_____
- ◯ Cirrhosis When:_____
- ◯ Kidney disease/dialysis When:_____
- ◯ Anemia When:_____
- ◯ Prior complications from anesthesia When:_____

Previous Procedures

- ◯ None
- ◯ Gallbladder removed — When:_____
- ◯ Appendectomy — When:_____
- ◯ Colon Resection — When:_____
- ◯ Hysterectomy — When:_____
- ◯ Exploratory Abdominal Surgery — When:_____
- ◯ Eye surgery — When:_____
- ◯ Rhinoplasty — When:_____
- ◯ Tonsillectomy — When:_____
- ◯ Mastectomy (R) breast — When:_____
- ◯ Mastectomy (L) breast — When:_____
- ◯ Lumpectomy breast — When:_____
- ◯ Arthroscopy — When:_____
- ◯ Hip Replacement — When:_____
- ◯ C-Section — When:_____
- ◯ Knee Surgery (Left, Right) — When:_____

Other:_____

Social History

Marital Status

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

Alcohol

- ◯ None

Type	Quantity	Frequency
◯ Wine		
◯ Beer		

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	Frequency
◯ History of drug use		
◯ Recreational drug use now		

Exercise

- ◯ None

Type	Quantity	Frequency
◯ Cardiovascular (Treadmill/Elliptical/Stairmaster)		
◯ Weightlifting		
◯ Yoga/Pilates		

Family Medical History

☐ No knowledge of family history

No family history of

☐ Celiac Sprue
☐ Crohn's Disease
☐ Colon Cancer
☐ Ulcerative Colitis

	Mother	Father	Sister	Brother	Other
Health Status					
Healthy	○	○	○	○	○
Seriously Ill	○	○	○	○	○
Diagnoses					
Celiac (Sprue)	○	○	○	○	○
Crohn's Disease	○	○	○	○	○
Colon Cancer	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

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

Cardiovascular

None	Y	N
chest pain	○	○
shortness of breath	○	○
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	○	○

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

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	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Respiratory

None	Y	N
asthma	○	○
cough	○	○
dyspnea	○	○
excessive sputum	○	○
hemoptisis	○	○
shortness of breath with exercise	○	○
shortness of breath after climbing stairs	○	○
wheezing	○	○

Reviewed with