GREATER HOUSTON
GASTROENTEROLOGY

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

- ⬭ Email
- ⬭ Cell phone
- ⬭ Telephone call - Home
- ⬭ Patient declines to specify
- Other:__________

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
- ⬭ Spanish; Castilian
- ⬭ Patient declines to specify

Allergies

- ⬭ Patient has no known allergies
- ⬭ Patient has no known drug allergies
- ⬭ Penicillins
- ⬭ Shellfish
- ⬭ Adhesive Tape
- ⬭ Codeine Sulfate
- ⬭ Latex
- ⬭ Sulfa (Sulfonamide Antibiotics)
- ⬭ Iodine And Iodide Containing Products
- Other:__________

Pharmacy

Name Address Phone

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

- [ ] Yes
- [ ] No

Current Medications

- [ ] None

Name	Dose	How taken?

Immunizations

- [ ] None

☐ Flu vaccine When:________ Other:________	☐ Hep B When:________	☐ Hep A, adult When:________	☐ Pneumovax When:________	☐ TB skin test When:________

Diagnostic Studies/Tests

- [ ] None

☐ EGD When:________	☐ Colonoscopy When:________	☐ Abdominal Ultrasound When:________	☐ MRI Abdomen/Pelvis When:________	☐ CT Abdomen When:________
☐ ERCP When:________	Other:________			

Past or Present Medical Conditions

- [ ] None

Gastroenterology:	☐ Colon cancer	☐ Colon polyp history	☐ Crohn's Disease	☐ Ulcerative Colitis
	☐ Ulcer Disease	☐ Gastroesophageal Reflux Disease (GERD)	☐ Cirrhosis	☐ Anemia
	☐ Diverticulosis	☐ Diverticulitis	☐ Hepatitis B	☐ Hepatitis C
	☐ H. Pylori Infection	☐ Irritable Bowel Syndrome	☐ Pancreatitis	☐ Gallstones
	☐ GI bleed	☐ Bowel Obstruction	☐ Hemorrhoids	☐ Hiatal hernia
	☐ Chronic constipation	Other:________	Other:________	
Cardiology:				
	☐ High blood pressure	☐ High Cholesterol	☐ Heart Murmurs	☐ Heart Attack/ Myocardial Infarction

- ○ Mitral Valve Prolapse/MR
- Other: ____
- ○ Valvular heart disease
- ○ Congestive Heart Failure
- Other: ____
- ○ Pacemaker
- ○ Coronary Artery Stents
- ○ Chronic atrial fibrillation
- Other: ____

Pulmonology:

- ○ Asthma
- ○ Sarcoidosis
- ○ C.O.P.D.
- ○ TB exposure
- ○ Blood Clots (lung)
- ○ Sleep apnea
- ○ Emphysema
- ○ Pulmonary Hypertension

Other:

- ○ Diabetes
- ○ HIV
- ○ Back pain
- ○ Hypothyroidism
- ○ BPH
- ○ Seizures
- ○ Fibrositis / Fibromyalgia
- Other: ____
- ○ Breast cancer
- ○ Osteoarthritis
- ○ Lung cancer
- Other: ____
- ○ Cataracts
- ○ Prostate Cancer
- ○ Renal Cell Carcinoma

Previous Procedures

- ○ None
- ○ Cholecystectomy-gallbladder removal
- ○ C-Section
- ○ Appendectomy
- ○ Coronary Artery Bypass Graft (CABG)
- ○ Carotid Endarterectomy
- ○ Exploratory Laparotomy
- ○ Heart valve replacement
- ○ Hemorrhoidectomy
- ○ Hiatal Hernia Repair
- ○ Hip Replacement
- ○ Pacemaker Insertion
- ○ Gastric bypass
- ○ Gastric Lap Band (banded gastroplasty)
- ○ Hernia repair (inguinal)
- ○ Hernia repair (umbilical)
- ○ Knee surgery
- ○ Hysterectomy
- Other: ____
- Other: ____

Family Medical History

- ○ No knowledge of family history

No family history of

- ○ Celiac sprue
- ○ Colon polyps
- ○ liver cancer
- ○ Stomach cancer
- ○ Colon cancer
- ○ Crohn's disease
- ○ Liver disease
- ○ Ulcerative Colitis / IBD

Health Status	Mother	Father	Brother	Sister	Son	Daughter	Grandmother	Grandfather
Healthy	○	○	○	○	○	○	○	○
Ill	○	○	○	○	○	○	○	○
Alive	○	○	○	○	○	○	○	○
	○	○	○	○	○	○	○	○
Deceased/At Age	____	____	____	____	____	____	____	____
Diagnoses								
Colon Cancer	○	○	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○	○	○
Lynch Syndrome	○	○	○	○	○	○	○	○

Cirrhosis ○ ○ ○ ○ ○ ○ ○ ○

Stomach cancer ○ ○ ○ ○ ○ ○ ○ ○

Other: ○ ○ ○ ○ ○ ○ ○ ○

Other: ○ ○ ○ ○ ○ ○ ○ ○

Other: ○ ○ ○ ○ ○ ○ ○ ○

Social History

Occupation:________________ Number of Children:________________

Marital Status

○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

○ Civil Union ○ Unknown ○ Other

Alcohol

○ None

Type / Number

○ Current

○ Former

Caffeine

○ None

○ Daily ○ Occasionally 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

Type	Started	Quit	Quantity	Frequency

Drug Use

○ None

○ Current ○ Former Type:________________

Exercise

○ None

Type / Number / Frequency

○ Exercise infrequently

○ Exercise reguarly

Review Of Systems

Allergic/Immunologic
None (Y N)
- HIV exposure
- persistent infections
- strong allergic reactions or urticaria
- Immunodeficiency

Cardiovascular
None (Y N)
- chest pain
- shortness of breath
- irregular heart beat
- palpitations
- peripheral edema
- fainting

Constitutional
None (Y N)
- fatigue
- fever
- loss of appetite
- sweats
- weight gain
- weight loss

ENMT
None (Y N)
- difficulty swallowing
- dizziness
- ear pain
- nose bleeds
- sore throat
- hearing loss

Endocrine
None (Y N)
- excessive thirst
- hair loss
- heat intolerance

Eyes
None (Y N)
- double vision
- loss of vision

Gastrointestinal
None (Y N)
- abdominal pain
- abdominal swelling
- change in bowel habits
- constipation
- diarrhea
- gas
- heartburn
- jaundice
- nausea
- rectal bleeding
- stomach cramps
- vomiting
- difficulty swallowing
- belching
- bloating
- black tarry stools
- rectal pain
- incontinence

Genitourinary
None (Y N)
- dark urine
- decrease in urine flow
- painful urination
- frequent urinary infections
- frequent urination
- blood in urine
- impotence
- waking to urinate
- 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
- memory loss

Psychiatric
None (Y N)
- anxiety
- depression
- difficulty sleeping
- hallucinations
- nervousness
- panic attacks
- paranoia

Respiratory
None (Y N)
- asthma
- cough
- shortness of breath
- excessive sputum
- coughing up blood
- shortness of breath with exercise
- wheezing

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

- [ ] Yes
- [ ] No

Reminder Preference

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

- [ ] Yes
- [ ] No

Reviewed with

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

Signature

Signature | Date