GI Excellence, Inc.

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GI Excellence, Inc. Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____

Race

☐ White/Caucasian ☐ Black or African American ☐ Asian ☐ Hispanic or Latino ☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander ☐ Mixed ☐ Other ☐ Unknown ☐ Patient declines to provide information

☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to provide information ☐ Prohibited by state law

Preferred Language

☐ English ☐ Spanish Other: _____

Allergies

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

☐ Aspirin, NSAIDs ☐ Codeine ☐ Penicillins ☐ Iodine ☐ Sulfa

☐ Latex ☐ Versed ☐ Fentanyl ☐ Propofol Other:

Current Medications

☐ None

Name Dose How taken?

_____

_____

_____

_____

☐ None

☐ Hep B When : _____ ☐ Flu vaccine When : _____ ☐ DTaP When : _____ ☐ Pneumovax When : _____

Diagnostic Studies/Tests

☐ None

☐ Endoscopy When: _____ ☐ Colonoscopy When: _____ ☐ CT Abdomen When: _____ ☐ CT Pelvis When: _____ ☐ Abdominal U/S When: _____

☐ Endoscopic Ultrasound When: _____ ☐ Abdominal MRI/MRCP When: _____ Other: _____ Other: _____ Other: _____

Past or Present Medical Conditions

☐ None

☐ Anemia When: _____

☐ Atrial Fibrilation When: _____

☐ Diabetes Mellitus When: _____

☐ Diverticulitis When: _____

☐ Coronary Artery Disease When: _____

☐ Barrets Esophagus When: _____

☐ Bleeding Ulcer When: _____

☐ Crohn's Disease When: _____

☐ Cirrhosis When: _____

☐ Colitis When: _____

☐ Colon cancer When: _____

☐ Colon polyps When: _____

☐ CVA When: _____

☐ Congestive Heart Failure When: _____

☐ Deep vein thrombosis When: _____

☐ Gallstones When: _____

☐ Gastritis When: _____

☐ GERD When: _____

☐ H. Pyloric When: _____

☐ Hemorrhoids When: _____

☐ Hepatitis When: _____

☐ Hepatitis B When: _____

☐ Hepatitis C When: _____

☐ Hiatal hernia When: _____

☐ High blood pressure When: _____

☐ IBS When: _____

☐ Iron Defficiency When: _____

☐ Myocardial infarction When: _____

☐ Peptic ulcer disease When: _____

☐ Pulmonary embolus When: _____

☐ S/p Gastric Bypass When: _____

☐ S/P GI bleed When: _____

☐ S/P Stents x3 When: _____

☐ TIA When: _____

Previous Procedures

☐ None:

☐ Aortic Valve Replacement When: _____

☐ Appendectomy When: _____

☐ Bladder Surgery When: _____

☐ Bypass Surgery When: _____

☐ C-Section When: _____

☐ Coronary Stents When: _____

☐ Colon Polyp removed When: _____

☐ Colon Resection When: _____

☐ Gallbladder removed When: _____

☐ Gastric Band When: _____

☐ Gastric By-Pass When: _____

☐ Hemicolectomy When: _____

☐ Hemorrhoidectomy When: _____

☐ Hysterectomy When: _____

☐ Inguinal Herniorraphy When: _____

☐ Liver biopsy When: _____

☐ Pacemaker When: _____

Social History

Occupation:

Number of Children:

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Civil Union

Alcohol

☐ None

	Type	Quantity	Frequency
☐	wine	glasses	Times / week
☐	beer	cans/bottles	Times / week
☐	liquor	shots	Times / week

Alcohol

☐ None

Type	Quantity	Frequency
☐ wine	glasses	Times / week
☐ beer	cans/bottles	Times / week
☐ liquor	shots	Times / week

Tobacco

Smoking Status

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker

☐ Smoker, current status unknown ☐ Unknown if ever smoked

Drug Use

☐ None

Type	Quantity	Frequency
☐		

Review Of Systems

	Yes	No
Allergic/Immunologic		
☐ None		
HIV exposure	☐	☐
persistent infections	☐	☐
strong allergic reactions or urticaria	☐	☐
Cardiovascular		
☐ None		
chest pain	☐	☐
shortness of breath	☐	☐
irregular heart beat	☐	☐
orthopnea	☐	☐
palpitations	☐	☐
peripheral edema	☐	☐
fainting or dizziness	☐	☐
Constitutional		
☐ None		
fatigue	☐	☐
fever	☐	☐
loss of appetite	☐	☐
malaise	☐	☐
sweats	☐	☐
weight gain	☐	☐
weight loss	☐	☐
ENMT		
☐ None		
difficulty swallowing	☐	☐
dizziness	☐	☐
double vision	☐	☐
ear pain	☐	☐
loss of vision	☐	☐
nasal obstruction	☐	☐
nose bleeds	☐	☐
photophobia	☐	☐
sore throat	☐	☐
Endocrine		
☐ None		
excessive thirst	☐	☐
hair loss	☐	☐
heat intolerance	☐	☐

	Yes	No
Gastrointestinal		
☐ None		
abdominal pain	☐	☐
abdominal swelling	☐	☐
change in bowel habits	☐	☐
constipation	☐	☐
diarrhea	☐	☐
gas	☐	☐
heartburn	☐	☐
jaundice	☐	☐
nausea	☐	☐
rectal bleeding	☐	☐
stomach cramps	☐	☐
vomiting	☐	☐
Genitourinary		
☐ None		
dark urine	☐	☐
decrease in urine flow	☐	☐
dysuria	☐	☐
frequent urinary infections	☐	☐
frequent urination	☐	☐
hematuria	☐	☐
impotence	☐	☐
nocturia	☐	☐
urethral discharge or incontinence	☐	☐
Hematologic/Lymphatic		
☐ None		
bleeding gums or palpable lymph nodes	☐	☐
easy bruising	☐	☐
prolonged bleeding	☐	☐
Integumentary		
☐ None		
allergies	☐	☐
dryness	☐	☐
hives	☐	☐
itching	☐	☐
jaundice	☐	☐
lesions	☐	☐
rashes	☐	☐

	Yes	No
Musculoskeletal		
☐ None		
arthritis	☐	☐
back pain	☐	☐
gout	☐	☐
joint deformity	☐	☐
joint pain	☐	☐
muscle weakness	☐	☐
stiffness	☐	☐
Neurological		
☐ None		
dizziness	☐	☐
fainting	☐	☐
frequent headaches	☐	☐
migraine	☐	☐
numbness or tingling	☐	☐
seizures	☐	☐
tremors	☐	☐
vertigo	☐	☐
Psychiatric		
☐ None		
anxiety	☐	☐
depression	☐	☐
difficulty sleeping	☐	☐
hallucinations	☐	☐
nervousness	☐	☐
panic attacks	☐	☐
paranoia	☐	☐
Respiratory		
☐ None		
asthma	☐	☐
cough	☐	☐
dyspnea	☐	☐
excessive sputum	☐	☐
hemoptysis	☐	☐
shortness of breath with excercise	☐	☐
wheezing	☐	☐

Pharmacy

Name: _____