Gastrointestinal & Liver Specialists of Tidewater, PLLC

PATIENT INTERVIEW FORM

First Name/Last Name____ Date of Birth____________________

Contact Preference: □Letter □Email □Cell Phone □Other___________________________

Allergies or sensitivities:
□Patient has no known allergies or sensitivities □Patient has no known drug/medication allergies or sensitivities

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Immunizations: □None

□Hepatitis A, adult When__________
□PPD When_________
□Flu vaccine When_________
□Hepatitis B When_________
□Pneumonia When_________

Diagnostic Studies/Tests: □None

□CT Abd/Pelvis/Chest When__________
□Endoscopy When__________
□Colonoscopy/Flexible Sigmoidoscopy When__________
□Liver Biopsy When__________
□Mammogram When_________
□ERCP When_________

Prior GI Physician? □ Seen a gastroenterologist in the past 3 years? □Yes □No When?________________ Who?________________________________

□ Seen recently in the ER or Hospital, if so where? Where?____________________________________

Previous procedures: □None

□Colon Polyp removed When__________
□Colon resection When__________
□Cholecystectomy When__________
□Pacemaker When__________
□Transplant-renal When__________
□Hysterectomy
□Gastric bypass
□Dialysis
□Other:______________________________

Past or Present Medical Conditions: □None

Gastrointestinal Conditions □Acid Reflux □Bleeding Ulcer □Crohn's Disease □Colitis □Gastric Ulcer □Gastritis □Diverticulitis □Hemorrhoids

Liver Disease □ Autoimmune Hepatitis □ Cirrhosis □Elevated Liver Function Test □ Hepatitis □ Hepatitis B □ Hepatitis C

General Medical
□Acute MI/Heart Attack □Anemia □Anxiety Disorder □Arthritis
□Asthma □Atrial Fibrillation □Autoimmune Disease □Back Pain (chronic)
□Bone Marrow Disease □Bronchitis □COPD □Carotid artery disease
□Chronic fatigue syndrome □Chronic kidney disease □Cluster headaches □Congestive heart failure
□Cystitis Interstitial □Deafness □Dementia □Depression
□Diabetes Mellitus □Elevated cholesterol □Emphysema □Endocarditis
□Fibromyalgia □Gallstones □Gout □Graves Disorder
□High Blood Pressure □Thyroid disease □IBS □Iron Defficiency
□HIV/AIDS □Kidney stones □Lupus □Lyme Disease
□Melanoma excision □Memory loss □Migraines □Neuropathy
□Osteoporosis □Parkinson’s □Peripheral vascular disease
□Pulmonary embolus □Renal Failure □Rheumatoid arthritis □Seizures
□Sleep apnea □Stroke □Other ____________________________________

Cancers
□Bladder cancer □Breast cancer □Colon cancer □Esophageal cancer
□Liver cancer □Lung cancer □Ovarian cancer □Pancreatic cancer
□Prostate cancer □Renal cell carcinoma □Skin cancer □Stomach cancer
□Uterine cancer

Social History Occupation____# of children____________

Marital Status □Single □Married □Divorced □Separated □Widowed

Alcohol □None

Type	Quantity	Number	Frequency - times per week
□Beer			
□Wine			
□Liquor			
□Other			

Caffeine □None □Tea □Coffee □Soda
□Other:______________________________

Tobacco
Smoking Status □Current every day smoker □Current some day smoker □Smoker, current status unknown
□Former smoker □Never smoked □Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency=Packs/day
□ Cigarettes	______	______	______	______
□ Cigars	______	______	______	______
□ Other	______	______	______	______

Drug use □None

Type	Quantity	Number	Frequency
□Intravenous drug use history	______	______	______
□Other	______	______	______

Exercise □None

Type	Frequency
□Walking	______
□Running	______
□Other	______

Family Medical History □No knowledge of family history
No family history of □Colon cancer □Polyps

Health Status	**Father**	**Mother**	**Sister**	**Brother**
Healthy	○	○	○	○
Ill (sick)	○	○	○	○
Deceased/at age	______	______	______	______
Diagnoses				
Family history of Colon Cancer	○	○	○	○
Family history of Colon Polyps	○	○	○	○
Family history of Colitis/Crohn's Disease	○	○	○	○
Family history of Gastrointestinal Cancer	○	○	○	○

Current Medications □None
Please attach a separate piece of paper if needed, to complete your list of medications.

Name of Medication	Dosage	Frequency
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______

Pharmacy Name______________________ Location______________________Phone______________________

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Review of Systems

Please check off any items you are currently experiencing problems with.

	√		√		√		√
Allergic/Immunologic		**Eyes**		**Integumentary**		**Respiratory**	
HIV exposure		double vision		allergies		asthma	
persistent infections		loss of vision		dryness		cough	
strong allergic reactions/hives		photophobia		hives		shortness of breath	
Cardiovascular		**Gastrointestinal**		itching		excessive sputum	
Chest pain		abdominal pain		lesions		coughing up blood	
SOB with exercise		abdominal swelling		rashes		SOB with exercise	
irregular heart beat		blood in stool		**Musculoskeletal**		wheezing	
orthopnea		change in bowel habits		arthritis			
palpitations		constipation		back pain			
peripheral edema		diarrhea		gout			
syncope		gas		joint deformity			
Constitutional		bloating		joint pain			
fatigue		heartburn		muscle weakness			
fever		jaundice		stiffness			
loss of appetite		nausea		**Neurological**			
malaise		rectal bleeding		dizziness			
sweats		stomach cramps		fainting			
weight gain		vomiting		frequent headaches			
weight loss		difficulty swallowing		migraine			
ENMT		**Genitourinary**		numbness or tingling			
difficulty swallowing		dark urine		seizures			
dizziness		decrease in urine flow		tremors			
ear pain		dysuria		vertigo			
nasal obstruction		frequent urinary infections		memory loss			
nose bleeds		frequent urination		**Psychiatric**			
sore throat		hematuria		anxiety			
hearing loss		impotence		depression			
Endocrine		nocturia		difficulty sleeping			
excessive thirst		urethral discharge		hallucinations			
hair loss		urethral incontinence		nervousness			
heat intolerance		**Hematologic/Lymphatic**		panic attacks			
		bleeding gums		paranoia			
		easy bruising					
		prolonged bleeding					