GI Associates of Maryland

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Reason for Visit _____

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:_____

Current Medications

☐ None

Name	Dose	How taken?

Allergies

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

Other:_____ Other:_____ Other:_____

Past or Present Medical Conditions

☐ None

- ☐ Chest Pain — When:_____
- ☐ Hypertension — When:_____
- ☐ Heart Attack — When:_____
- ☐ Diabetes — When:_____
- ☐ Hepatitis B — When:_____
- ☐ Asthma — When:_____
- ☐ Cancer — When:_____
- ☐ Ulcer — When:_____
- ☐ Kidney Disease — When:_____
- ☐ Stroke — When:_____
- ☐ Hepatitis C — When:_____
- Other:_____
- Other:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Civil Union

Tobacco

Smoking Status

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

☐ Smoker, current status unknown ☐ Unknown if ever smoked

	Type	Started	Quit	Quantity	Frequency
☐	Cigarettes				

Alcohol

☐ None

☐ Type Beer,Wine,Liquor Quantity Frequency

☐ Quit

Caffeine

☐ None

☐ Coffee ☐ Soda ☐ Tea

Previous Procedures

☐ None

☐ Appendectomy When:_____ ☐ Gallbladder When:_____ ☐ Hysterectomy When:_____ Other:_____

Diagnostic Studies/Tests

☐ None

☐ Colonoscopy When:_____ ☐ Endoscopy When:_____ Other:_____ Other:_____

Family Medical History

☐ No knowledge of family history

No family history of ☐ Colon Cancer ☐ Stomach Cancer ☐ colon polyp

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Other
Colon Polyp	○	○	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○	○

Review Of Systems

	Yes	No
Allergic/Immunologic		
○ None		
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○
Cardiovascular		
○ None		
chest pain	○	○
Shortness of breath with exercise	○	○
irregular heart beat	○	○
palpitations	○	○
Swelling of the arms and legs	○	○
fainting	○	○
Hypertension	○	○
Heart Attack	○	○
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	○	○
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	○	○
painful urination	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○
impotence	○	○
nocturia	○	○
urethral discharge or incontinence	○	○
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	○	○
Respiratory		
○ None		
asthma	○	○
cough	○	○

Pharmacy

Name: _____

Signature

_____

Patient Signature Date