Fall Hill 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:_____

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 ☐ Prohibited by state law

Ethnicity

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

Sex

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ Patient declines to specify

Contact Preference

☐ Letter ☐ Cell Phone ☐ Home Phone ☐ Patient declines to specify Other:_____

Reminder Preference

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

☐ Yes ☐ No

Consent to Share Data

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

☐ Yes ☐ No

Pharmacy

Name Address Phone

Allergies

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

☐ Latex ☐ Peanuts ☐ Eggs Other: Other:

Other: Other: Other: Other: Other:

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

☐ Hep B ☐ PPD ☐ Hep A Other:

When: When: When:

Past or Present Medical Conditions

☐ None

Cardiovascular ☐ Coronary Heart Disease ☐ High blood pressure ☐ Chronic Kidney Disease ☐ High Cholesterol

Other:

Pulmonary	☐ Asthma	☐ COPD	☐ Sleep apnea	Other:_____
Endocrine	☐ Diabetes Mellitus	☐ Thyroid Disease	Other:_____	
Gastrointestinal	☐ Hemorrhoids	☐ Reflux	☐ colon polyps	☐ Liver Disease
	☐ Crohn's Disease	☐ Ulcerative Colitis	Other:_____	
Other	☐ Depression	☐ Anxiety	Other:_____	

Previous Procedures

☐ None

☐ Gastric Bypass - type unspecified
When:_____
Other:_____

☐ Joint Replacement - site unspecified
When:_____

☐ Hysterectomy
When:_____

☐ Appendectomy
When:_____

☐ Gallbladder Removal
When:_____

Diagnostic Studies/Tests

☐ None

☐ EGD (Upper Endoscopy)
When:_____

☐ Colonoscopy
When:_____

☐ Flexible Sigmoidoscopy
When:_____

☐ Video Capsule Endoscopy
When:_____

Other:_____

Social History

Occupation:_____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
☐ Civil Union ☐ Unknown ☐ Other

Alcohol

☐ None

☐ Beer ☐ Wine ☐ Liquor ☐ Less than 7 per week ☐ More than 7 per week

Caffeine

☐ None

☐ Soft Drink ☐ Coffee ☐ Tea

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

☐ Recreational drug use

Exercise

None

Type Frequency

Family Medical History

No knowledge of family history

No family history of Colon cancer Colon polyps

	Mother	Father	Brother	Sister	Grandmother	Grandfather	Other
Diagnoses							
Diabetes mellitus	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○
Colon Polyps, Family History	○	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○	○
GERD	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○
Gallstones	○	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic	Y	N
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular	Y	N
chest pain	○	○
irregular heart beat	○	○
palpitations	○	○
peripheral edema	○	○

Constitutional	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

ENMT	Y	N
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
sore throat	○	○

Endocrine	Y	N
excessive thirst	○	○
heat intolerance	○	○

Eyes	Y	N
Cataracts	○	○
Glaucoma	○	○

Gastrointestinal	Y	N
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
difficulty swallowing	○	○

Genitourinary	Y	N
dark urine	○	○
dysuria	○	○
frequent urination	○	○
hematuria	○	○

Hematologic/Lymphatic	Y	N
Cancer	○	○
easy bruising	○	○
prolonged bleeding	○	○

Integumentary	Y	N
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○

Musculoskeletal	Y	N
joint pain	○	○
muscle weakness	○	○

Neurological	Y	N
frequent headaches	○	○
migraine	○	○
seizures	○	○
memory loss	○	○

Psychiatric	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○

Respiratory	Y	N
asthma	○	○
cough	○	○
dyspnea	○	○
wheezing	○	○

Reviewed with

○ Patient ○ Parent ○ Guardian ○ Not Present

Signature

Signature Date