# Modesto Gastroenterology Medical Corporation

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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

☐ Other Race ☐ Unknown ☐ Patient declines to specify

**Ethnicity**

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Unknown

**Sex**

☐ Male ☐ Female ☐ Other

**Preferred Language**

☐ English ☐ Spanish; Castilian ☐ Patient declines to specify

**Contact Preference**

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Portal Messages ☐ Patient declines to specify

Other:_____

### Allergies

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

☐ Latex ☐ Penicillins ☐ Sulfa (Sulfonamide Antibiotics) Other:_____

## Current Medications

☐ None

| Name | Dose | How taken? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Immunizations

☐ None

☐ Flu Vaccine When:_____

☐ Hep A, adult When:_____

☐ Hep B, adult When:_____

☐ Pneumonia When:_____

Other:_____

## Diagnostic Studies/Tests

☐ None

☐ Colonoscopy When:_____

☐ EGD (Upper Endoscopy) When:_____

☐ Radiology Testing When:_____

## Past or Present Medical Conditions

☐ None

☐ Colon polyps

☐ Colon cancer

☐ Rectal Cancer

☐ Uterine Cancer

☐ Hypertension

☐ Diabetes Mellitus

☐ Hepatitis C

☐ High cholesterol

☐ Ulcerative Colitis

☐ Crohns Disease

☐ Lower gastrointestinal bleeding

☐ Upper gastrointestinal bleeding

## Previous Procedures

☐ None

☐ Blood Transfusions When:_____

☐ Surgery/ Procedure _____ When:_____

☐ Surgery/ Procedure _____ When:_____

## Family Medical History

☐ No knowledge of family history

**No family history of** ☐ Colon cancer ☐ Colon Polyps ☐ Esophageal Cancer ☐ Stomach Cancer

| **Health Status** | Mother | Father | Brother | Sister | Maternal Grandmother | Paternal Grandmother | Maternal Grandfather | Paternal Grandfather |
|---|---|---|---|---|---|---|---|---|
| Deceased/At Age | ○ ____ | ○ ____ | ○ ____ | ○ ____ | ○ ____ | ○ ____ | ○ ____ | ○ ____ |
| Cause of Death | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| **Diagnoses** | | | | | | | | |
| Colon Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon Polyps | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Stomach Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Esophageal Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Uterine Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Breast cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Other: | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

## Social History

Occupation:_____ Number of Children:_____

**Marital Status**

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

**Alcohol**

☐ None

| Type | Quantity | Frequency |
|---|---|---|
| ☐ Beers | | |
| ☐ Wine | | |
| ☐ Other: | | |

**Drug Use**

☐ None

☐ Marijuana ☐ Cocaine ☐ Other

**Caffeine**

☐ None

☐ Coffee ☐ Tea ☐ Soda ☐ Other

**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 |
|---|---|---|---|---|
| ◯ Cigarettes | | | | |
| ◯ Cigar | | | | |
| ◯ Smokeless | | | | |

**Exercise**

- ◯ None
- ◯ Yes

## Review Of Systems

**Allergic/Immunologic**

| ◯ None | Y | N |
|---|---|---|
| HIV exposure | ◯ | ◯ |
| persistent infections | ◯ | ◯ |
| strong allergic reactions or urticaria | ◯ | ◯ |

**Cardiovascular**

| ◯ None | Y | N |
|---|---|---|
| chest pain | ◯ | ◯ |
| Heart Attack | ◯ | ◯ |
| Heart Murmur | ◯ | ◯ |
| High Blood Pressure | ◯ | ◯ |
| High cholesterol | ◯ | ◯ |
| irregular heart beat | ◯ | ◯ |
| Leg Cramps | ◯ | ◯ |
| palpitations | ◯ | ◯ |
| Other | ◯ | ◯ |

**Constitutional**

| ◯ None | Y | N |
|---|---|---|
| fatigue | ◯ | ◯ |
| fever | ◯ | ◯ |
| loss of appetite | ◯ | ◯ |
| weight gain | ◯ | ◯ |
| weight loss | ◯ | ◯ |

**ENMT**

| ◯ None | Y | N |
|---|---|---|
| Loss of Hearing | ◯ | ◯ |
| nose bleeds | ◯ | ◯ |
| Ringing in Ears | ◯ | ◯ |
| sore throat | ◯ | ◯ |

**Endocrine**

| ◯ None | Y | N |
|---|---|---|
| excessive thirst | ◯ | ◯ |
| hair loss | ◯ | ◯ |
| heat intolerance | ◯ | ◯ |

**Eyes**

| ◯ None | Y | N |
|---|---|---|
| Cataracts | ◯ | ◯ |
| Glasses | ◯ | ◯ |
| Glauoma | ◯ | ◯ |
| loss of vision | ◯ | ◯ |

**Gastrointestinal**

| ◯ None | Y | N |
|---|---|---|
| abdominal pain | ◯ | ◯ |
| black stool | ◯ | ◯ |
| change in bowel habits | ◯ | ◯ |
| constipation | ◯ | ◯ |
| diarrhea | ◯ | ◯ |
| Difficulty Swallowing | ◯ | ◯ |
| gas | ◯ | ◯ |
| heartburn | ◯ | ◯ |
| Hepatitis | ◯ | ◯ |
| jaundice | ◯ | ◯ |
| nausea | ◯ | ◯ |
| rectal bleeding | ◯ | ◯ |
| stomach cramps | ◯ | ◯ |
| vomiting | ◯ | ◯ |
| weight loss | ◯ | ◯ |

**Genitourinary**

| ◯ None | Y | N |
|---|---|---|
| Blood in Urine | ◯ | ◯ |
| frequent urination | ◯ | ◯ |
| Painful urination | ◯ | ◯ |
| Lack of bladder control | ◯ | ◯ |
| kidney stones | ◯ | ◯ |
| Testicular Pain | ◯ | ◯ |
| Testicular Swelling | ◯ | ◯ |

**Hematologic/Lymphatic**

| ◯ None | Y | N |
|---|---|---|
| bleeding gums or palpable lymph nodes | ◯ | ◯ |
| easy bruising | ◯ | ◯ |
| prolonged bleeding | ◯ | ◯ |

**Integumentary**

| ◯ None | Y | N |
|---|---|---|
| allergies | ◯ | ◯ |
| dryness | ◯ | ◯ |
| hives | ◯ | ◯ |
| itching | ◯ | ◯ |

**Musculoskeletal**

| ◯ None | Y | N |
|---|---|---|
| arthritis | ◯ | ◯ |
| back pain | ◯ | ◯ |
| Osteoporosis | ◯ | ◯ |

**Neurological**

| ◯ None | Y | N |
|---|---|---|
| Stroke | ◯ | ◯ |
| TIA | ◯ | ◯ |
| seizures | ◯ | ◯ |
| fainting | ◯ | ◯ |
| frequent headaches | ◯ | ◯ |
| migraine | ◯ | ◯ |

**Psychiatric**

| ◯ None | Y | N |
|---|---|---|
| anxiety | ◯ | ◯ |
| depression | ◯ | ◯ |
| Schizophrenia | ◯ | ◯ |
| Suicidal Attempts | ◯ | ◯ |
| panic attacks | ◯ | ◯ |

**Respiratory**

| ◯ None | Y | N |
|---|---|---|
| asthma | ◯ | ◯ |
| wheezing | ◯ | ◯ |
| Cough blood | ◯ | ◯ |
| Shortness of breath | ◯ | ◯ |
| Sleep Apnea | ◯ | ◯ |

## Pharmacy

Name Address Phone

## Consent to Import Medication History

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

Yes No

## Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities (e.g. referring physician, labs, pathology, hospitals).

Yes No

## Reminder Preference

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

Yes No

## Signature

Signature Date