WILMINGTON GASTROENTEROLOGY

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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

☐ Telephone call ☐ Patient declines to specify Other:_____

Allergies

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

☐ Latex ☐ Shellfish ☐ Seafood Other:_____

Antibiotics ☐ Cipro ☐ Erythromycin ☐ Flagyl ☐ Sulfa (Sulfonamide Antibiotics) ☐ Penicillins

Other Medications ☐ Aspirin ☐ Codeine Sulfate ☐ Demerol ☐ fentanyl citrate (PF) ☐ morphine ☐ propofol ☐ Tylenol ☐ Iv Dye, Iodine Containing Contrast Media

Current Medications

☐ None

Name	Dose	How taken?

Past or Present Medical Conditions

☐ None

☐ Acid Reflux	☐ Anemia	☐ Anxiety disorder	☐ Asthma	☐ Atrial Fibrillation
☐ Back Pain (chronic)	☐ Barrett's Esophagus	☐ Breast cancer	☐ Chronic Lung Disease	☐ Cirrhosis
☐ Colitis	☐ Colon Cancer	☐ Colon polyps	☐ Congestive Heart Failure	☐ Crohn's Disease
☐ Depression	☐ Diabetes Mellitus	☐ Diverticulitis	☐ Diverticulosis	☐ Duodenal Ulcer
☐ Emphysema	☐ Fatty Liver	☐ Urinary tract infection (frequent)	☐ Gall stones	☐ Glaucoma
☐ Gout	☐ Heart Attack	☐ Heart Murmurs	☐ Hemorrhoids	☐ Hepatitis
☐ Hepatitis B	☐ Hepatitis C	☐ Hiatal hernia	☐ High blood pressure	☐ Elevated Cholesterol
☐ History of suicide attempt	☐ HIV / AIDS	☐ Hyperthyroidism	☐ Hypothyroidism	☐ Irritable Bowel Syndrome
☐ Kidney Disease	☐ Kidney Failure	☐ Kidney Stones	☐ Lactose intolerance	☐ Lupus
☐ Migraines	☐ Osteoarthritis	☐ Osteoporosis	☐ Pancreatitis	☐ Parkinsons
☐ Pneumonia	☐ PTSD	☐ Rheumatoid arthritis	☐ Sexually Transmitted Disease	☐ Seizures
☐ Skin Cancer	☐ Sleep apnea	☐ Stomach Ulcer	☐ Stroke	☐ TB exposure
☐ Ulcerative Colitis				

Previous Procedures

☐ None

☐ Appendectomy When:____	☐ Breast When:____	☐ C-Section When:____	☐ Cataract surgery When:____	☐ CATH - Cardiac When:____
☐ Colon Resection When:____	☐ Colonoscopy When:____	☐ Colostomy When:____	☐ Defibrillator When:____	☐ Dialysis When:____
☐ EGD / Upper endoscopy When:____	☐ ERCP When:____	☐ EUS When:____	☐ Flexible Sigmoidoscopy When:____	☐ Gallbladder Removed When:____
☐ Heart Bypass When:____	☐ Hemorrhoids procedure When:____	☐ Hepatitis C screening When:____	☐ Hernia Repair - Hiatal - Umbilical - Inguinal When:____	☐ Joint replacement When:____
☐ Kidney When:____	☐ Liver biopsy When:____	☐ Obesity surgery When:____	☐ Ovary surgery When:____	☐ Pacemaker When:____
☐ Peg tube When:____	☐ Prostate When:____	☐ Stomach When:____	☐ Thyroidectomy When:____	☐ Tonsillectomy When:____
☐ Tubal Ligation When:____	☐ Uterus When:____	Other:____		

Social History

Occupation:____ Number of Children:____

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Civil Union
- [ ] Unknown
- [ ] Other

Alcohol

- [ ] None
- [ ] Rarely
- [ ] Daily
- [ ] Socially

Caffeine

- [ ] None

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

	Type	Quantity	Frequency
[ ]	Recreational and Illicit Drug Use		

Exercise

- [ ] None

Type	Quantity	Frequency

Family Medical History

- [ ] No knowledge of family history

No family history of

- [ ] Celiac disease
- [ ] Colon cancer
- [ ] Esophageal cancer
- [ ] Gastric cancer
- [ ] IBD
- [ ] Liver disease
- [ ] Pancreatic cancer
- [ ] Pancreatitis
- [ ] Polyps

Diagnoses	Mother	Father	Brother	Sister	Daughter	Son	Other
Colon cancer	○	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○	○
Esophageal cancer	○	○	○	○	○	○	○
Stomach cancer	○	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○	○
Pancreatic cancer	○	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

None	Y	N
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

None	Y	N
chest pain	○	○
irregular heart beat	○	○
ankle swelling	○	○
heart murmur	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
chills	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

ENMT

None	Y	N
nose bleeds	○	○
sore throat	○	○
blurred vision	○	○
hoarseness	○	○

Gastrointestinal

None	Y	N
abdominal pain	○	○
anal/rectal pain	○	○
abdominal swelling or bloating	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
blood in stool	○	○
dificulty swallowing	○	○
black stool	○	○
hemorrhoids	○	○
incontinence	○	○
rectal urgency	○	○

Endocrine

None	Y	N
hair loss	○	○
heat intolerance	○	○

Genitourinary

None	Y	N
dark urine	○	○
frequent urination	○	○
blood in urine	○	○
painful urination	○	○

Hematologic/Lymphatic

None	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○
swollen glands	○	○

Musculoskeletal

None	Y	N
back pain	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

None	Y	N
dizziness	○	○
frequent headaches	○	○
tremors	○	○
memory disturbance	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
nervousness	○	○
panic attacks	○	○

Respiratory

None	Y	N
cough	○	○
shortness of breath	○	○
wheezing	○	○
coughing up blood	○	○

Pharmacy

Name Address Phone

Reviewed with

○ Patient ○ Parent ○ Guardian ○ Not Present

Signature Date

Current Medication List

Name:_____ Date:_____

Date of Birth:_____

*** Please complete prior to your first visit to our office.**

Medication Name	Dosage	Number of times taken per day

Wilmington Gastroenterology Associates

Demographics

Patient Name _____ Date of Birth ____/____/_____
(First) (Middle) (Last)

Address _____City _____State_____ Zip_____

Home Ph: _____-_____-_____ Cell Ph: _____-_____-_____ Work Ph: _____-_____-_____

Social Security _____-_____-_____ Sex: **M F** Email address_____
(*circle)*

Emergency Contact _____ Ph: _____-_____-_____ 2nd Ph: _____-_____-_____

Can we release your health care information to your emergency contact? Y or N

Primary Doctor _____Primary Doctor Phone _____-_____-_____

Preferred Pharmacy/Location_____

How did you find out about us? A) another doctor referred you B) yellow pages C) a friend or family member D)_____

Your healthcare information - HIPAA Privacy Practices Acknowledgment

I have received a copy of Wilmington Gastroenterology Associates HIPAA privacy notice that explains how my Protected Health Information (PHI) may be used. Additional copies of the Notice of Privacy Practices are available at the front desk. Questions about our Notice of Privacy Practices may be directed to:
Attn: Privacy Officer Wilmington Gastroenterology, 5115 Oleander Drive, Wilmington, NC 28403

I acknowledge receipt of Wilmington Gastroenterology's privacy practices. In addition, my medical information may be shared with the individuals listed below. (Please exclude any doctors)

☐ **Please check this box if you do not want us to disclose your PHI to anyone**

OR list anyone that we may release your healthcare information to below:

_____	_____	_____	_____
Name and relationship	Phone	Name and relationship	Phone
_____	_____	_____	_____
Name and relationship	Phone	Name and relationship	Phone

☐ Please check this box if it is OK to leave a message on your answering machine that contains PHI

Consent for Treatment: I hereby authorize the performance of medical treatment that may be advised or recommended by Wilmington Gastroenterology Associates, including necessary and/or beneficial services and use of equipment in the performance of the treatment.

Financial Agreement: I understand the Wilmington Gastroenterology files insurance as a courtesy and that I am ultimately responsible for payment for the services provided. I authorize Wilmington Gastroenterology to furnish any necessary information to insurance carriers concerning my illness/treatment and request payment be made directly to Wilmington Gastroenterology.

X _____ _____
Patient / Guardian signature Date