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

☐ Unknown ☐ Patient declines to specify

Ethnicity

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

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 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

Previous Procedures

- ☐ None

- ☐ Blood Transfusions When:_____
- ☐ Procedure _____ When:_____
- ☐ 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:		

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				

Drug Use

○ None

○ Marijuana ○ Cocaine ○ Other

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.

Yes No

Reminder Preference

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

Yes No

Reviewed with

Patient Parent Guardian Not Present

Signature

Signature Date