GASTROENTEROLOGY CENTER OF NORTHERN VIRGINIA, LTD.

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Patient Interview Form

Patient Information

First Name: Ada Last Name: Reyes

Date Of Birth: _____

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 ◯ Prohibited by state law

Ethnicity

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

Sex

◯ Male ◯ Female ◯ Other ◯ Unknown

Preferred Language

◯ English ◯ Patient declines to specify

Contact Preference

◯ Letter ◯ Email ◯ Patient declines to specify Other: _____

Pharmacy

Name Address Phone

Allergies

◯ Patient has no known allergies ◯ Patient has no known drug allergies

◯ Adhesive Tape ◯ Codeine Sulfate ◯ Erythromycin ◯ Penicillins ◯ Shellfish
◯ Iv Dye, Iodine Containing ◯ Latex gloves

Current Medications

☐ None

Name	Dose	How taken?

Immunizations

☐ None

☐ Flu vaccine When:_____ ☐ Hep A When:_____ ☐ Hep B When:_____ ☐ Pneumovax When:_____ ☐ TB skin test When:_____

Diagnostic Studies/Tests

☐ None

☐ Colonoscopy When:_____ ☐ EGD When:_____ ☐ CT Abdomen/Pelvis When:_____ ☐ MRI Abdomen/Pelvis When:_____ ☐ ERCP When:_____

☐ Flexible Sigmoidoscopy When:_____ ☐ Cologuard When:_____ ☐ FOBT When:_____

Previous Procedures

☐ None

☐ Gallbladder removed ☐ Appendectomy ☐ Colon resection ☐ Small Bowel Resection ☐ Exploratory Laparoscopy

☐ Gastric Bypass ☐ Gastric Lap Band ☐ Hemorrhoidectomy ☐ Hemorrhoid banding ☐ Abdominoplasty

☐ Hysterectomy - Abdominal ☐ Bilateral Tubal Ligation (BTL) ☐ Mastectomy R Breast ☐ Pacemaker Insertion ☐ Defibrillator Placement

☐ Coronary Artery Bypass Graft (CABG) ☐ Abdominal aortic aneurysm (AAA) repair ☐ Heart valve replacement ☐ Cardiac Cath - with stent placement ☐ Joint Replacement

☐ Back Surgery ☐ Fibromyalgia Other:_____ Other:_____

Past or Present Medical Conditions

☐ None

Gastroenterology/Hepatology

☐ Colon polyp history ☐ Colon cancer ☐ Irritable Bowel Syndrome ☐ Diverticulitis

☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Gastroesophageal Reflux Disease (GERD) ☐ Barrett's Esophagus

☐ Ulcer Disease ☐ Hepatitis B ☐ Hepatitis C ☐ Fatty Liver

☐ Cirrhosis ☐ Celiac Disease ☐ Bowel Obstruction ☐ Pancreatitis

☐ Anemia Other:_____ Other:_____

Cardiology

☐ Coronary Artery Disease ☐ Congestive Heart Failure ☐ Heart Attack ☐ High blood pressure

☐ Atrial Fibrillation ☐ Vascular Disease ☐ High Cholesterol ☐ Stroke

☐ Transient Ischemic Attack ☐ Valvular heart disease ☐ Pacemaker ☐ Coronary Artery Stents

Other:_____ Other:_____

Pulmonology

☐ C.O.P.D. ☐ Asthma ☐ Sleep apnea ☐ Blood Clots (leg)

☐ Blood Clots (lung) ☐ Wheezing Other:_____ Other:_____

Other

- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Bipolar disorder
- ☐ Body piercings
- ☐ Breast cancer
- ☐ Current pregnancy
- ☐ Depression
- ☐ Diabetes Mellitus, Insulin Dependent (Type 1)
- ☐ Diabetes Mellitus, Non-Insulin Dependent (Type 2)
- ☐ Fibrositis / Fibromyalgia
- ☐ Gout
- ☐ HIV exposure
- ☐ HIV infection
- ☐ Hypothyroidism
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Lung cancer
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer
- ☐ Seizures
- ☐ Tattoos

Social History

Occupation: _____ Number of Children: _____

Marital Status

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

Alcohol

- ☐ None
- ☐ Occasionally
- ☐ Daily

Caffeine

- ☐ None
- ☐ Occasionally
- ☐ Daily

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				
☐ Chewing Tobacco				

Drug Use

- ☐ None

Type	Quantity	Number	Frequency
☐ IV or intranasal drugs			Times / month
☐ Recreational			Times / month

Exercise

- ☐ None
- ☐ Regular exercise
- ☐ Occasional exercise

Family Medical History

- ☐ No knowledge of family history

No family history of

- ☐ Celiac sprue
- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Crohn's disease

Liver disease
Ulcerative Colitis / IBD
Stomach cancer

	Mother	Father	Sister	Brother	Grandmother	Grandfather
Health Status						
Age/Date of Birth						
Healthy	O	O	O	O	O	O
Ill	O	O	O	O	O	O
Seriously Ill	O	O	O	O	O	O
Disabled	O	O	O	O	O	O
In Remission	O	O	O	O	O	O
Alive	O	O	O	O	O	O
Deceased/At Age	O	O	O	O	O	O
Cause of Death						
Diagnoses						
Celiac Disease	O	O	O	O	O	O
Colon cancer	O	O	O	O	O	O
Colon polyps	O	O	O	O	O	O
Crohn's disease	O	O	O	O	O	O
Gallbladder disease	O	O	O	O	O	O
Liver disease	O	O	O	O	O	O
Ulcerative colitis	O	O	O	O	O	O
Other:	O	O	O	O	O	O

Review Of Systems

Allergic/Immunologic

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

Cardiovascular

◯ None	Y	N
chest pain	◯	◯
dyspnea with exercise	◯	◯
irregular heart beat	◯	◯
orthopnea	◯	◯
palpitations	◯	◯
peripheral edema	◯	◯
syncope	◯	◯

Constitutional

◯ None	Y	N
fatigue	◯	◯
fever	◯	◯
loss of appetite	◯	◯
malaise	◯	◯
sweats	◯	◯
weight gain	◯	◯
weight loss	◯	◯

ENMT

◯ None	Y	N
difficulty swallowing	◯	◯
dizziness	◯	◯
ear pain	◯	◯
nasal obstruction	◯	◯
nose bleeds	◯	◯
sore throat	◯	◯
hearing loss	◯	◯

Endocrine

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

Eyes

◯ None	Y	N
double vision	◯	◯
loss of vision	◯	◯
photophobia	◯	◯

Gastrointestinal

◯ None	Y	N
abdominal pain	◯	◯
abdominal swelling	◯	◯
change in bowel habits	◯	◯
constipation	◯	◯
diarrhea	◯	◯
gas	◯	◯
heartburn	◯	◯
jaundice	◯	◯
nausea	◯	◯
rectal bleeding	◯	◯
stomach cramps	◯	◯
vomiting	◯	◯

Genitourinary

◯ None	Y	N
dark urine	◯	◯
decrease in urine flow	◯	◯
dysuria	◯	◯
frequent urinary infections	◯	◯
frequent urination	◯	◯
hematuria	◯	◯
impotence	◯	◯
nocturia	◯	◯
urethral discharge or incontinence	◯	◯

Hematologic/Lymphatic

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

Integumentary

◯ None	Y	N
allergies	◯	◯
dryness	◯	◯
hives	◯	◯
itching	◯	◯
jaundice	◯	◯
lesions	◯	◯
rashes	◯	◯

Musculoskeletal

◯ None	Y	N
arthritis	◯	◯
back pain	◯	◯
gout	◯	◯
joint deformity	◯	◯
joint pain	◯	◯
muscle weakness	◯	◯
stiffness	◯	◯

Neurological

◯ None	Y	N
dizziness	◯	◯
fainting	◯	◯
frequent headaches	◯	◯
migraine	◯	◯
numbness or tingling	◯	◯
seizures	◯	◯
tremors	◯	◯
vertigo	◯	◯
memory loss	◯	◯

Psychiatric

◯ None	Y	N
anxiety	◯	◯
depression	◯	◯
difficulty sleeping	◯	◯
hallucinations	◯	◯
nervousness	◯	◯
panic attacks	◯	◯
paranoia	◯	◯

Respiratory

◯ None	Y	N
asthma	◯	◯
cough	◯	◯
dyspnea	◯	◯
excessive sputum	◯	◯
coughing up blood	◯	◯
shortness of breath with exercise	◯	◯
wheezing	◯	◯

difficulty swallowing ○○

Consent to Import Medication History

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

○ 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