SYRACUSE GASTROENTEROLOGICAL ASSOCIATES, P.C.

Patient Interview Form

First Name _____ Last Name_____ Maiden/other names_____

Date of Birth_____ Age_____ Height_____ Weight_____ ☐ Male ☐ Female

Email
Please check one as your preferred email for communications

◯ Personal:_____ ◯ Work:_____

Contact Preference

◯ Telephone call ◯ Email marked above ◯ Patient Portal ◯ Patient declines to specify Other:_____

Preferred Language

◯ English ◯ Spanish; Castilian ◯ Patient declines to specify

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

Reminder Preference

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

◯ Yes ◯ No

Immunizations

◯ None

◯ PPD When:_____ ◯ Flu vaccine When:_____ ◯ Pneumococcal vaccine When:_____ ◯ Hep A When:_____ ◯ Hep B When:_____

◯ TdaP When:_____

PATIENT INITIALS _____ DOB _____

Allergies

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

Drug Allergies	☐ Codeine Sulfate	☐ Penicillins	☐ Sulfa (Sulfonamide Antibiotics)	☐ aspirin (bulk)
	☐ Altazine	☐ Tetracyclines	Other:	Other:
Other Allergies	☐ Latex	☐ Surgical Tape	Other:	
Food Allergies	☐ Nuts	☐ Shellfish	Other:	

Current Medications

☐ None

Name	Dose	How taken?

Consent to Import Medication History

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

☐ Yes ☐ No

Pharmacy

Name	Address	Phone

Past or Present Medical Conditions

☐ None

Infectious Diseases	☐ MRSA	☐ VRE	☐ ESBL	☐ C-DIFF
Lower GI	☐ Hx of Colon polyps	☐ Hx Colon Cancer	☐ Lynch syndrome (HNPCC)	☐ Crohn's Disease
	☐ Colitis	☐ Ulcerative Colitis	☐ Diverticulitis	☐ Diverticulosis
	☐ IBS	Other:		
Upper GI	☐ Esophagitis	☐ Hiatal hernia	☐ Barrett's Esophagus	☐ GERD
Misc	☐ Anemia	☐ Asthma	☐ Heart Disease	☐ Heart Attack/Angina
	☐ Hepatitis	☐ Hypertension	☐ Pacemaker	☐ Diabetes
	☐ Seizures	☐ Stroke	☐ ICD (Defib Device)	☐ Tuberculosis
	☐ Sleep apnea	☐ Thyroid disorder	Other:	
Other Issues	☐ S/P R Knee Replacement	☐ Heart Valve Replacement	☐ Hip Replacement	Other:

PATIENT INITIALS _____ DOB _____

Diagnostic Studies/Tests

- ◯ None

- ◯ Upper GI Series When:_____
- ◯ Fecal Hemoccult Slides When:_____
- ◯ Flexible Sigmoidoscopy When:_____
- ◯ Sonogram When:_____
- ◯ CT Scan When:_____
- ◯ Barium Enema When:_____
- ◯ Colonoscopy When:_____
- ◯ Panendoscopy When:_____
- ◯ MRI When:_____
- ◯ DEXA Scan When:_____

Other:_____

Previous Procedures

- ◯ None

- ◯ Cesarean Section (C-Section) When:_____
- ◯ Hysterectomy When:_____
- ◯ Esophageal Dilatation When:_____
- ◯ Gallbladder removed When:_____
- ◯ Appendectomy When:_____

Previous surgeries

- ◯ Hernia Repair When:_____
- Other:_____
- Other:_____
- Other:_____

Family Medical History

- ◯ No knowledge of family history

No family history of

- ◯ ABDOMINAL CANCER
- ◯ COLITIS
- ◯ COLON CANCER
- ◯ COLON POLYPS
- ◯ GASTROINTESTINAL CANCER

Health Status	Mother	Father	Sister	Brother	Daughter	Son	Other
Healthy	◯	◯	◯	◯	◯	◯	◯
Ill	◯	◯	◯	◯	◯	◯	◯
Alive	◯	◯	◯	◯	◯	◯	◯
Deceased/At Age	◯____	◯____	◯____	◯____	◯____	◯____	◯____
Cause of Death	_____	_____	_____	_____	_____	_____	_____
Diagnoses							
COLON CANCER	◯	◯	◯	◯	◯	◯	◯
COLON POLYPS	◯	◯	◯	◯	◯	◯	◯
COLITIS	◯	◯	◯	◯	◯	◯	◯
ABDOMINAL CANCER	◯	◯	◯	◯	◯	◯	◯
STOMACH CANCER	◯	◯	◯	◯	◯	◯	◯
ESOPHAGEAL CANCER	◯	◯	◯	◯	◯	◯	◯
OTHER GASTROINTESTINAL CONDITION	◯	◯	◯	◯	◯	◯	◯

Social History

Occupation:_____ Number of Children:_____

Marital Status

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

Caffeine

- ◯ None
- ◯ Coffee daily
- ◯ Coffee twice daily
- ◯ Coffee >=3 cups daily
- ◯ Tea daily
- ◯ Tea twice daily
- ◯ Tea >=3 cups daily
- ◯ Soda daily
- ◯ Soda twice daily
- ◯ Soda >= 3 cups 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				
◯ Smokeless				
◯ Other				

Alcohol

- ◯ None

Type	Quantity	Number	Frequency
◯ Beer			
◯ Wine			

Drug Use

- ◯ None

Type	Quantity	Number	Frequency
◯ Recreational			

Exercise

- ◯ None

Type	Quantity	Number	Frequency
◯ Walking			
◯ Running			
◯ Other			

Consent to Share Data

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

- ◯ Yes
- ◯ No

PATIENT INITIALS _____ DOB _____

Review Of Systems

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or hives	○	○

Cardiovascular

None	Y	N
chest pain	○	○
short of breath 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	○	○
double vision	○	○
ear pain	○	○
loss of vision	○	○
nasal obstruction	○	○
nose bleeds	○	○
sensitivity to light	○	○
sore throat	○	○

Endocrine

None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○
thyroid disease	○	○

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	○	○
painful urination	○	○
frequent urinary infections	○	○
frequent urination	○	○
blood in urine	○	○
impotence	○	○
nighttime urination	○	○
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	○	○

Psychiatric

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

Respiratory

None	Y	N
asthma	○	○
cough	○	○
shortness of breath at rest	○	○
excessive sputum	○	○
coughing up blood	○	○
shortness of breath with exercise	○	○
wheezing	○	○

Signature _____ Date _____