CHARLESTON GI
Charleston Gastroenterology Specialists
Charleston Endoscopy Center
Summerville Endoscopy Center

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

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Sex
☐ Male ☐ Female ☐ Other

Preferred Language
☐ English ☐ Patient declines to specify

Contact Preference
☐ Email ☐ Home phone ☐ Home or cell phone ☐ Cell Phone ☐ Patient declines to specify

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

Allergies

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

☐ Latex ☐ Adhesive Tape ☐ Iv Dye, Iodine containing ☐ Shellfish ☐ erythromycin (bulk)

☐ Penicillins ☐ Sulfa (Sulfonamide Antibiotics) ☐ Demerol ☐ propofol ☐ morphine

☐ fentanyl ☐ midazolam ☐ codeine sulfate ☐ Nickel sensitivity ☐ Soy

☐ Eggs

Pharmacy

Name Address Phone

Consent to Import Medication History

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

☐ Yes ☐ No

Current Medications

☐ None

Immunizations

☐ None

☐ Flu vaccine When:_____ ☐ Hep A When:_____ ☐ Hep B When:_____ ☐ Pneumovax When:_____ ☐ PPD When:_____

Diagnostic Studies/Tests

☐ None

☐ CT Abdomen When:_____ ☐ Abdominal Ultrasound When:_____ ☐ MRI Abdomen/Pelvis When:_____ ☐ Gastric Emptying Study When:_____ ☐ Barium Swallow When:_____

☐ EGD When:_____ ☐ Colonoscopy When:_____ ☐ ERCP When:_____ ☐ Lab work When:_____

Previous Procedures

- ☐ None
- ☐ Pacemaker Insertion Manufacturer: Serial Number: When:_____
- ☐ Defibrillator Placement Manufacture: Serial #: Note: When:_____
- ☐ Bilateral Tubal Ligation (BTL) When:_____
- ☐ Hysterectomy When:_____
- ☐ C-Section When:_____
- ☐ Abdominal Surgery When:_____
- ☐ Cholecystectomy When:_____
- ☐ Appendectomy When:_____
- ☐ Hernia repair When:_____
- ☐ Bowel resection When:_____
- ☐ Gastric Bypass When:_____
- ☐ Gastric Lap Band (banded gastroplasty) When:_____
- ☐ Colon resection When:_____
- ☐ Hemorrhoidectomy When:_____
- ☐ Hemorrhoid banding When:_____
- ☐ Exploratory Laparoscopy When:_____
- ☐ Bladder Surgery When:_____
- ☐ Mastectomy When:_____
- ☐ Back surgery When:_____
- ☐ Joint Replacement (in the last year) When:_____
- ☐ Abdominal aortic aneurysm (AAA) repair When:_____
- ☐ Coronary Artery Bypass Graft (CABG) When:_____
- ☐ Cardiac Cath - with stent placement When:_____

Social History

Marital Status

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

Alcohol

- ☐ None
- ☐ Weekends only
- ☐ 1 drink per day
- ☐ 2 drinks per day
- ☐ occasional
- ☐ 1 drink per week
- ☐ 2-3 drinks per week
- ☐ 3-4 drinks per week

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	Quit	Quantity	Frequency
☐ Cigarettes			
☐ Chewing Tobacco			

Drug Use

- ☐ None
- ☐ Marijuana
- ☐ Cocaine
- ☐ Heroin
- ☐ Other

Family Medical History

☐ No knowledge of family history

No family history of

☐ Celiac Disease
☐ Colon Polyps
☐ Liver Cancer
☐ Colon Cancer
☐ Irritable bowel syndrome

Diagnoses	Father	Mother	Sister	Brother	Son	Daughter
Colon CA, Family History	○	○	○	○	○	○
Colon Polyps, Family History	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○
Celiac disease	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Inflammatory bowel disease	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○

Past or Present Medical Conditions

- [ ] None

Heart Disease	[ ] High blood pressure	[ ] Myocardial infarction	[ ] Congestive Heart Failure	[ ] Atrial Fibrillation
	[ ] Hyperlipidemia	[ ] CAD	[ ] Mitral Valve Prolapse	
Lung Disease	[ ] Asthma	[ ] Wheezing	[ ] Emphysema	[ ] Sleep Apnea
	[ ] COPD	[ ] Home Oxygen Therapy	[ ] Blood Clot (Lungs)	
Neurological Disorders	[ ] Stroke	[ ] Seizures	[ ] Migraine Headaches	[ ] Spinal Nerve Stimulator
	[ ] TIAs			
Blood/Clotting Disorders	[ ] Anemia	[ ] Thrombocytopenia	[ ] Blood Thinners	
Gastrointestinal Disorders	[ ] Reflux	[ ] Gastric Ulcers	[ ] Barrett's	[ ] Gastric Polyps
	[ ] Crohn's Disease	[ ] Ulcerative Colitis	[ ] H/O Diverticulitis	[ ] Colon Polyps
	[ ] Irritable bowel syndrome	[ ] Celiac disease	[ ] Bowel Obstruction	[ ] Pancreatitis
	[ ] Cirrhosis			
Diabetes	[ ] Insulin Dependent Diabetes Mellitus	[ ] Non-Insulin Dependent Diabetes Mellitus	[ ] Diet Controlled Diabetes Mellitus	
Cancer	[ ] Colon Cancer	[ ] Esophageal Cancer	[ ] Gastric Cancer	[ ] Pancreatic Cancer
	[ ] Liver Cancer	[ ] Lung Cancer	[ ] Breast Cancer	[ ] Ovarian Cancer
	[ ] Skin Cancer	[ ] Prostate Cancer		
Infectious Diseases	[ ] Hepatitis B	[ ] Hepatitis C	[ ] HIV	[ ] Shingles (active)
	[ ] Chicken Pox (active)	[ ] MRSA	[ ] VRE	
Other	[ ] Personal History Malignant Hyperthermia	[ ] Family History Malignant Hyperthermia	[ ] Glaucoma	[ ] Hypothyroidism
	[ ] Fibromyalgia	[ ] Anxiety disorder	[ ] Depression	[ ] Bipolar Disorder
	[ ] Arthritis	[ ] Kidney Disease	[ ] Dialysis	
Pregnancy	[ ] Pregnancy: No - Neg urine HCG	[ ] Pregnancy: No - Hysterectomy	[ ] Pregnancy: No- Post Menopause	[ ] Pregnancy: Yes - Positive HCG
	[ ] Pregnancy: No- Tubal ligation	[ ] Pregnancy: Pt refused urine HCG; denies possibility of pregnancy	[ ] Prenancy - No - LMP within the last 28 days	
TB Screen	[ ] No signs or symptoms of TB	[ ] Fever	[ ] Night Sweats	[ ] Unexplained Wt Loss
	[ ] Persistent Cough >2 wks			

Review Of Systems

Cardiovascular

○ None	Y	N
chest pain	○	○
arm / leg swelling	○	○

Constitutional

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

ENMT

○ None	Y	N
difficulty swallowing	○	○
ear pain	○	○
nose bleeds	○	○
sore throat	○	○
hearing loss	○	○
ringing	○	○

Endocrine

○ None	Y	N
excessive thirst	○	○
heat intolerance	○	○
cold intolerance	○	○
profuse sweating	○	○

Eyes

○ None	Y	N
pain	○	○
redness	○	○
vision change	○	○

GastroIntestinal

○ None	Y	N
abdominal pain	○	○
abdominal swelling	○	○
constipation	○	○
diarrhea	○	○
black, tarry stools	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
vomiting	○	○
difficulty swallowing	○	○
reflux	○	○
chronic itching	○	○
anal itching	○	○
anal pain	○	○

Genitourinary

○ None	Y	N
frequent urination	○	○
hematuria	○	○
urethral discharge or incontinence	○	○
burning	○	○

Hematologic/Lymphatic

○ None	Y	N
easy bruising	○	○
hematology	○	○
ease of bleeding	○	○

Integumentary

○ None	Y	N
itching	○	○
rashes	○	○
hair or nail changes	○	○
lumps	○	○

Musculoskeletal

○ None	Y	N
stiffness	○	○
neck pain	○	○
lumps on neck	○	○
calf pain	○	○
leg cramping	○	○

Neurological

○ None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
numbness or tingling	○	○
seizures	○	○
memory loss	○	○
head injury	○	○

Psychiatric

○ None	Y	N
anxiety	○	○
depression	○	○
nervousness	○	○

Respiratory

○ None	Y	N
cough	○	○
shortness of breath with exercise	○	○
wheezing	○	○
pain with breathing	○	○

Reviewed with

○ Patient ○ Parent ○ Guardian ○ Not Present