GANV
GASTROENTEROLOGY ASSOCIATES
OF NORTHERN VIRGINIA

PATIENT INTERVIEW FORM

Name: ____
Last First M. I.

Birthdate: ____/_____/_________ Age: ________

Sex: ❑ M ❑ F Height: ___________ Weight: ________

I consent to having my medical and demographic information shared with other healthcare providers. ❑ Yes ❑ No

Reminder Preference

I would like to receive preventive care and follow up care reminders. ❑ Yes ❑ No

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies. ❑ Yes ❑ No

______________________________	____________________	____________________
Preferred Pharmacy Name / Address	Phone	Fax

______________________________	____________________	____________________
Primary Care Physician	Phone	Fax
______________________________	____________________	____________________
Referring Physician	Phone	Fax
______________________________	____________________	____________________
Cardiologist	Phone	Fax
______________________________	____________________	____________________
Other Specialist	Phone	Fax

CURRENT MEDICATIONS

Drug Allergies: ❑ No ❑ Yes **If yes, please list:** ______________________________

Prescription Medications: (List any prescription medications that you are currently taking)

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

OVER THE COUNTER MEDICATIONS: (List any non-prescription medications you are taking, including herbal medicine and vitamins.)

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		

ARE YOU TAKING ANY BLOOD THINNER MEDICATIONS? ❑ No ❑ Yes, please list below

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		

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DIAGNOSED GASTROINTESTINAL CONDITIONS		❑ None
❑ Alcohol Abuse	❑ Diverticulitis	❑ Intestinal Obstruction
❑ Anal Fissures	❑ Diverticulosis	❑ Inflammatory Bowel Disease
❑ Antibiotic Treatment (within 3 months)	❑ Esophageal Stricture	❑ Irritable Bowel Syndrome
❑ Barrett's Esophagus	❑ Gastric Ulcer	❑ Liver Disease
❑ Celiac Disease	❑ Gastrointestinal Bleeding	❑ Liver Failure
❑ Crohn's Disease	❑ GERD	❑ Pancreatitis
❑ Cirrhosis, Liver Failure	❑ Helicobacter Pylori (H. Pylori)	❑ Stomach Ulcer
❑ Clostridium Difficile Infection (C.Diff)	❑ Hemorrhoids	❑ Ulcerative Colitis
❑ Colon Polyps	❑ Hemochromatosis	❑ Yellow /Jaundice
❑ Colitis	❑ Hepatitis, Type: ____________	❑ Other GI Conditions
❑ Disorder of Gallbladder	❑ Hiatal Hernia	Please List: _______________
		__________________________

NON-GASTROINTESTINAL CONDITIONS		❑ None
❑ Anemia	❑ Fibromyalgia	❑ Psoriasis
❑ Apnea/Sleep Apnea	❑ Goiter	❑ Pulmonary Embolism
Device used: ❑ No ❑ Yes	❑ Heart Attack	❑ Respiratory Problem
List Type: _________________	❑ Heart Disease	❑ Rheumatic Fever
❑ Arthritis	❑ Heart Murmur	❑ Seizure Disorder
❑ Asthma	❑ High Blood Pressure	❑ Stroke
❑ Bleeding Disorder	❑ High Cholesterol	❑ Thyroid Disease
❑ Blood Clots	❑ HIV Positive	❑ Tuberculosis
❑ COPD	❑ Kidney Disease	❑ Unspecified atherosclerosis
❑ Cardiac Arrhythmia (Example: A. Fib)	Type: _______________	❑ Other Medical Conditions
❑ Congestive Heart Failure	❑ Lupus	Please list: __________________
❑ Diabetes: Type I___	❑ Leukemia	____________________________
Type II___	❑ Multiple Sclerosis (MS)	____________________________
❑ Exposure to HIV	❑ MRSA	____________________________
❑ Emphysema	❑ Pneumonia	____________________________

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DIAGNOSTIC STUDIES/TESTS ❑ None

❑ Colonoscopy

Date: _______________

❑ EGD (Upper Endoscopy)

❑ ERCP

❑ EUS

❑ Flexible Sigmoidoscopy

❑ MRI Abdomen/Pelvis (Within Past 6 months)

Date: ____________ Findings: ___________________________

❑ Abdominal Ultrasound (Within Past 6 months)

Date: ____________ Findings: ___________________________

❑ CT Abdomen/Pelvis (Within Past 6 months)

Date: ____________ Findings: ___________________________

PREVIOUS PROCEDURES ❑ None

❑ Abdominal Aortic Aneurysm (AAA)

Repaired? ❑ No ❑ Yes

If yes, provide date: _________________

❑ Appendectomy

❑ Back Surgery

❑ Breast Surgery

❑ Cardiac Cath with Stent Placement

If yes, provide date: __________________

❑ Cesarean Section

❑ Colectomy/Colon Resection

❑ Coronary Artery Bypass Grafting (CABG)

Provide Date: _______________

❑ Craniotomy/Brain Surgery

❑ Defibrillator Placement

❑ Gallbladder

❑ Gastric/Stomach Surgery

❑ Hernia Repair

Type: _______________

❑ Hip Replacement

❑ Hysterectomy

❑ Knee Surgery

❑ Pacemaker Placement

❑ Shoulder Surgery

❑ Tonsillectomy

❑ Transplant, Liver

Date: __________________

❑ Transplant, Other

Type: __________________

Date: __________________

❑ Tubal Ligation

❑ TURP

❑ Other Procedures/Surgeries

Please list: _________________

____

____

____

PERSONAL HISTORY

Alcohol Consumption

❑ None ❑ Daily
❑ Weekly ❑ Occasional
❑ 1-3 drinks daily ❑ 5 or More
❑ Previous

Caffeine

❑ None ❑ Daily
❑ Weekly ❑ Occasional
❑ 1-3 cups daily ❑ 5 or More
❑ Previous

Drug Use

❑ None ❑ Marijuana ❑ IV
❑ Cocaine ❑ Previous Drug Use
❑ Other: ____________________
____

Do You Smoke? **❑ Never Smoked** ❑ Former Smoker
❑ Unknown if Ever Smoked ❑ Current Everyday Smoker ❑ Current Smoker, Status Unknown
❑ Current Smoker, Some Days ❑ Light Tobacco Smoker ❑ Heavy Tobacco Smoker

How Many Packs Do You Smoke Per Day? ❑ 1-2 Packs Per Day ❑ 3 or More Packs Per Day ❑ Other

FAMILY MEDICAL HISTORY

	YES	NO	RELATIONSHIP	AGE OF ONSET
CANCERS:				
❑ **Breast**				
❑ **Colon**				
❑ **Ovarian**				
❑ **Pancreatic**				
❑ **Rectal**				
❑ **Stomach**				
❑ **Uterine**				
❑ **Other**				
________________				
COLON POLYP(S)				
Barrett's Esophagus				
Bleeding or Clotting Disorder Type: _____________				
Celiac Disease				
Crohn's Disease				
Gallbladder Disorder				
Hepatitis B				
Hepatitis C				
Liver Disease				
Pancreatic Disease				
Ulcerative Colitis				
Ulcer Disease				

SYSTEMS REVIEW

In the past six (6) months, have you had any of the following symptoms?

CARDIOVASCULAR

❑ None
❑ Chest Pain
❑ Elevated Blood Pressure
❑ Fainting
❑ Swelling of Extremities

CONSTITUTIONAL

❑ Fatigue
❑ Fever
❑ Loss of Appetite
❑ Night Sweat
❑ Sudden Weight Loss

ENDOCRINE

❑ None
❑ Excessive Thirst
❑ Fatigue
❑ Heat Intolerance
❑ Sweating

ENMT

❑ None
❑ Ear Pain
❑ Hearing Loss
❑ Hoarseness
❑ Nasal Obstruction
❑ Nose Bleed

EYES

❑ None
❑ Corrected Vision
❑ Loss of Vision

GASTROINTESTINAL

❑ None
❑ Abdominal Pain
❑ Abdominal Swelling
❑ Black Stool
❑ Blood in Stool
❑ Change in bowel habits
❑ Constipation
❑ Diarrhea
❑ Difficulty of Swallowing
❑ Food Intolerance
❑ Gas/Flatulence
❑ Heartburn
❑ Incontinence of Stool
❑ Nausea
❑ Pain with Bowel Movements
❑ Stomach Cramps
❑ Rectal Bleeding

GENITOURINARY

❑ None
❑ Blood in Urine
❑ Dark Urine
❑ Enlarged Prostate
❑ Frequent Urination
❑ Painful Urination

INTEGUMENTARY

❑ None
❑ Hives
❑ Jaundice
❑ Itching
❑ Rashes

MUSCULOSKELETAL

❑ None
❑ Back Pain
❑ Joint Pain
❑ Muscle Weakness
❑ Stiffness

RESPIRATORY

❑ None
❑ Cough
❑ Coughing up Blood
❑ Difficulty Breathing
❑ Shortness of Breathing

OTHER:

____

____

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IMMUNIZATION		
❑ None	❑ Flu Vaccine Date: _______________	❑ PCV 7 (Pneumonia) Date: __________________

____ _____________________________

Signature Date

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