GI HEALTH Hawaii

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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Contact Preference

- ☐ Email
- ☐ Cell phone
- ☐ Telephone call-Work
- ☐ Telephone call - Home
- ☐ Patient Portal
- ☐ Patient declines to specify
- Other:_____

Email

Please check one as your preferred email for communications

- ☐ Personal:_____
- ☐ Work:_____

Preferred Language

- ☐ Chinese
- ☐ English
- ☐ Japanese
- ☐ Korean
- ☐ Samoan
- ☐ Spanish; Castilian
- ☐ Tagalog
- ☐ Tonga (Tonga Islands)
- ☐ Vietnamese
- ☐ 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
- ☐ Other Race
- ☐ Unknown
- ☐ Patient declines to specify

Ethnicity

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

Sex

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Unknown

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

Social History

Occupation:_____ Number of Children:_____

Marital Status

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

Alcohol

☐ None

Type	Number	Frequency
☐ Rarely		Times / year
☐ Occasionally		Times / month
☐ Moderately		Times / week
☐ Daily		Times / day

Caffeine

☐ None

☐ Daily ☐ Occasionally

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

Drug Use

☐ None

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

Exercise

☐ None

Type	Number	Frequency
☐ Occasional		Times / month
☐ Regular		Times / week

Immunizations

- [ ] None

- [ ] Flu vaccine — When:_____
- [ ] Pneumovax — When:_____
- [ ] Hep A — When:_____
- [ ] Hep B — When:_____
- Other:_____

Diagnostic Studies/Tests

- [ ] None

- [ ] EGD — When:_____
- [ ] Colonoscopy — When:_____
- [ ] Flexible Sigmoidoscopy — When:_____
- [ ] ERCP — When:_____
- [ ] EUS — When:_____
- [ ] Abdominal Ultrasound — When:_____
- [ ] CT Abdomen/Pelvis — When:_____
- [ ] MRI Abdomen/Pelvis — When:_____
- [ ] Mammogram — When:_____

Previous Procedures

- [ ] None

- [ ] Abdominal aortic aneurysm (AAA) repair — When:_____
- [ ] Appendectomy — When:_____
- [ ] Back Surgery — When:_____
- [ ] Bariatric Surgery — When:_____
- [ ] Bilateral Tubal Ligation (BTL) — When:_____
- [ ] Breast Surgery — When:_____
- [ ] Cardiac Cath - with stent placement — When:_____
- [ ] Cholecystectomy — When:_____
- [ ] Colon resection/ Colectomy — When:_____
- [ ] Coronary Artery Bypass Graft (CABG) — When:_____
- [ ] D & C — When:_____
- [ ] Defibrillator Placement — When:_____
- [ ] Exploratory Laparoscopy — When:_____
- [ ] Fundoplication - Nissen (Acid Reflux) — When:_____
- [ ] Heart valve replacement — When:_____
- [ ] Hemorrhoid banding — When:_____
- [ ] Hemorrhoidectomy — When:_____
- [ ] Hysterectomy — When:_____
- [ ] Joint Replacement — When:_____
- [ ] Pacemaker Insertion — When:_____
- [ ] PEG tube placement — When:_____
- [ ] Small Bowel Resection - Segmental — When:_____
- [ ] Whipple Procedure (Pancreatico-duodenectomy) — When:_____
- Other:_____

Past or Present Medical Conditions

☐ None

Cardiology

☐ Angina When: _____
☐ Anticoagulation Therapy When: _____
☐ Arrhythmia When: _____
☐ Atrial Fibrillation When: _____
☐ Brain Aneurysm When: _____
☐ Congestive Heart Failure When: _____
☐ Coronary Artery Stents When: _____
☐ Coronary Artery Disease When: _____
☐ Defibrillator When: _____
☐ Heart Attack When: _____
☐ Heart Murmurs When: _____
☐ Hyperlipidemia When: _____
☐ Hypertension When: _____
☐ Mitral Valve Prolapse/MR When: _____
☐ Myocardial infarction When: _____
☐ Pacemaker When: _____
☐ Palpitations When: _____
☐ Stroke When: _____
☐ Transient Ischemic Attack When: _____
☐ Vascular Disease When: _____

Other: _____

Gastroenterology

☐ Barrett's Esophagus When: _____
☐ Celiac Disease When: _____
☐ Colon polyp When: _____
☐ Crohn's Disease When: _____
☐ Diverticulitis When: _____
☐ Diverticulosis When: _____
☐ Gastroesophageal Reflux Disease (GERD) When: _____
☐ Gastric Ulcer When: _____
☐ Gastritis When: _____
☐ H. Pylori Infection When: _____
☐ Hemorrhoids When: _____
☐ Irritable Bowel Syndrome When: _____
☐ Iron Deficiency Anemia When: _____
☐ Ulcer Disease When: _____
☐ Ulcerative Colitis When: _____

Other: _____

Hepatology

☐ Cirrhosis When: _____
☐ Elevated Liver Function Test When: _____
☐ Fatty Liver When: _____
☐ Gallstones When: _____
☐ Hepatitis A When: _____
☐ Hepatitis B When: _____
☐ Hepatitis C When: _____
☐ Pancreatitis When: _____

Other: _____

Pulmonology

☐ Asthma When: _____
☐ Blood Clots When: _____
☐ C.O.P.D. When: _____
☐ Emphysema When: _____
☐ Sleep apnea When: _____
☐ Wheezing When: _____

Other: _____

Oncology

☐ Breast cancer When: _____
☐ Colon cancer When: _____
☐ Gastric Cancer When: _____
☐ Lung cancer When: _____
☐ Ovarian Cancer When: _____
☐ Prostate Cancer When: _____
☐ Skin Cancer When: _____

Other: _____

Other

☐ Current pregnancy When: _____
☐ Anxiety disorder When: _____
☐ Arthritis When: _____
☐ Bipolar disorder When: _____
☐ Body piercings When: _____
☐ Cataracts When: _____
☐ Carpal Tunnel Syndrome When: _____
☐ Depression When: _____
☐ Diabetes Mellitus, Insulin Dependent (Type 1) When: _____
☐ Diabetes Mellitus, Non-Insulin Dependent (Type 2) When: _____
☐ Fibrositis / Fibromyalgia When: _____
☐ Gout When: _____
☐ Hematuria When: _____
☐ HIV infection When: _____
☐ Hypothyroidism When: _____
☐ Kidney disease When: _____
☐ Kidney stones When: _____
☐ Migraines When: _____
☐ Obesity When: _____
☐ Osteoporosis When: _____

☐ Psoriasis	☐ Renal Failure	☐ Seizures	☐ Tattoos
When:_____	When:_____	When:_____	When:_____

Other:_____

Family Medical History

☐ No knowledge of family history

No family history of

- ☐ Anesthesia reactions
- ☐ Celiac sprue
- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Crohn's disease
- ☐ Liver disease
- ☐ Stomach cancer
- ☐ Ulcerative Colitis / IBD

Diagnoses	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Anesthesia reactions	○	○	○	○	○	○	○	○
Celiac disease	○	○	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○	○	○
Stomach cancer	○	○	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Adhesive Tape
- ☐ Codeine Sulfate
- ☐ Erythromycin
- ☐ Penicillins
- ☐ Propofol Analogues
- ☐ IV Dye, Iodine And Iodide Containing Products
- ☐ Latex
- ☐ Soy
- ☐ Eggs
- ☐ Shellfish

Other: _____

Current Medications

- ☐ None

Name	Dose	How taken?

Pharmacy

Name	Address	Phone

Consent to Import Medication History

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

- ☐ Yes
- ☐ No

Reviewed with

- ☐ Patient
- ☐ Parent
- ☐ Guardian
- ☐ Not Present

Signature

Signature	Date

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	○	○
difficulty swallowing	○	○

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	○	○