MONMOUTH GASTROENTEROLOGY, LLC

A Division of Allied Digestive Health, LLC

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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:______________________

Contact Preference

- ⬭ Cell number
- ⬭ Any method
- ⬭ Patient Portal HIPAA compliant email
- ⬭ Patient declines to specify
- Other:____________

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

Sex

- ⬭ Male
- ⬭ Female
- ⬭ Other

Preferred Language

- ⬭ English
- ⬭ Spanish; Castilian
- ⬭ Patient declines to specify

Allergies

- Patient has no known allergies
- Patient has no known drug allergies

- Aspirin (Tartrazine Only)
- Penicillins
- Codeine Sulfate
- Bactrim/Sulfa
- Milk
- NSAID's
- Kiwi
- Eggs
- Peanuts
- Latex
- Band-Aids
- Morphine
- Iodine injectable Dye

Other:______________

Consent to Import Medication History

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

- Yes
- No

Pharmacy

Name	Address	Phone

Current Medications

- None

Name	Dose	How taken?

Immunizations

- None

- Hep A — When:______________
- Hep B — When:______________
- HPV — When:______________
- Flu Vaccine — When:______________
- MMR — When:______________
- Pnuemovax — When:______________
- Tetanus — When:______________
- varicella — When:______________

Other:______________

Diagnostic Studies/Tests

- None

- Abdominal Ultrasound — When:______________
- Bone densitometry (DEXA) — When:______________
- Colonoscopy — When:______________
- CT Abdomen/Pelvis — When:______________
- EGD — When:______________
- ERCP — When:______________
- EUS — When:______________
- Flexible Sigmoidoscopy — When:______________
- Mammogram — When:______________
- MRI Abdomen/Pelvis — When:______________
- Small Bowel Imaging — When:______________

Other:______________

Previous Procedures

- None

- Appendectomy — When:______________
- C-Section — When:______________
- Cardiac stent — When:______________
- Colon Resection — When:______________
- Gall Bladder Removal — When:______________
- Hysterectomy — When:______________
- Lung Surgery — When:______________
- Obesity Surgery — When:______________
- Defibrillator — When:______________
- Pacemaker — When:______________

Other:______________

Past or Present Medical Conditions

- None

Acid Reflux When:______	Arrhythmia When:______	Arthritis When:______	Asthma When:______	Celiac Disease When:______
Cirrhosis When:______	Colon cancer When:______	Colon polyps When:______	Congestive Heart Failure When:______	C.O.P.D. When:______
Coronary artery disease When:______	Crohn's Disease When:______	Depression When:______	Diverticulitis When:______	Diabetes Mellitus, insulin dependent When:______
Diabetes Mellitus, non-insulin dependent When:______	Elevated cholesterol When:______	Gout When:______	Heart Attack When:______	Hepatitis B When:______
Hepatitis C When:______	HIV When:______	Hypertension When:______	Hyperthyroidism When:______	Hypothyroidism When:______
Irritable Bowel Syndrome When:______	Kidney Disease When:______	Liver Disease When:______	MRSA When:______	Osteopenia When:______
Osteoporosis When:______	Seizures When:______	Sleep apnea When:______	Stroke (CVA) When:______	Transient Ischemic Attack When:______
Ulcerative Colitis When:______	Urinary Incontinence When:______	Valvular heart disease When:______	Other:______	

Social History

Occupation:______ Number of Children:______

Marital Status

Single	Married	Divorced	Separated	Widowed
Civil Union	Unknown	Other		

Alcohol

- None

Type	Quantity	Number	Frequency
Beer			
Hard Liquor			
Wine			

Caffeine

- None

Coffee	Soft Drink	Tea	Chocolate

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	Quantity	Number	Frequency
Recreational Drug Use			

Exercise

☐ None

Type	Quantity	Number	Frequency

Family Medical History

☐ No knowledge of family history

No family history of ☐ Colon cancer ☐ Polyps

Health Status	Mother	Father	Sister	Brother
Alive	○	○	○	○
Deceased/At Age	○ ____	○ ____	○ ____	○ ____
Cause of Death	____	____	____	____

Diagnoses	Mother	Father	Sister	Brother
Barrett's Esophagus	○	○	○	○
Breast Cancer	○	○	○	○
Colon Polyps	○	○	○	○
Colorectal Cancer	○	○	○	○
Esophageal Cancer	○	○	○	○
Gynecologic Cancers	○	○	○	○
Liver Cancer	○	○	○	○
Liver Disease	○	○	○	○
Lung Cancer	○	○	○	○
Pancreatic Cancer	○	○	○	○
Prostate Cancer	○	○	○	○
Stomach Cancer	○	○	○	○
Ulcerative colitis/Crohn's Disease	○	○	○	○
Other:	○	○	○	○

Review Of Systems

Allergic/Immunologic

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

Cardiovascular

None	Y	N
chest pain	◯	◯
become very short of breath with normal excercise	◯	◯
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	◯	◯
sensitivity to light	◯	◯

Gastrointestinal

None	Y	N
difficulty swallowing	◯	◯
heartburn	◯	◯
abdominal pain	◯	◯
abdominal swelling	◯	◯
change in bowel habits	◯	◯
constipation	◯	◯
diarrhea	◯	◯
gas	◯	◯
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	◯	◯
Urinary Incontinence	◯	◯
Urinary Discharge	◯	◯

Hematologic/Lymphatic

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

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	◯	◯

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

Reviewed with

Patient   Parent   Guardian   Not Present

Signature

Signature   Date