Genesis HEALTHCARE

COASTAL GASTROENTEROLOGY
A Division of Genesis Healthcare
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mygenesishealth.com

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

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 ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law

Sex

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ Spanish; Castilian ☐ Patient declines to specify

Contact Preference

☐ Letter ☐ Portal Message ☐ Patient declines to specify

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

☐ Aspirin ☐ Demerol ☐ Iodine ☐ Morphine ☐ Penicillins

☐ Sulfa ☐ Valium ☐ Versed ☐ 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

Social History

Occupation:_____ Number of Children:_____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Alcohol

☐ None

Type	Quantity	Number	Frequency

☐ I quit using alcohol _____

Exercise

☐ None

Type	Quantity	Number	Frequency

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

Current Symptoms

Allergic/Immunologic

None	Y	N
flu	○	○
HIV exposure	○	○
persistent infections	○	○
pneumonia	○	○
Strong Allergic Reaction	○	○

Cardiovascular

None	Y	N
ankle swelling	○	○
chest pain	○	○
murmur	○	○
palpitations	○	○
shortness of breath (lying down)	○	○
shortness of breath (with exercise)	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
weight gain	○	○
weight loss	○	○
malaise	○	○
night sweats	○	○

Endocrine

None	Y	N
cold intolerance	○	○
excessive thirst	○	○
hair/nail changes	○	○

ENMT

None	Y	N
hearing loss	○	○
nose bleeds	○	○
sore throat	○	○
difficulty swallowing	○	○
hoarseness	○	○

Eyes

None	Y	N
night sensitivity	○	○
pain	○	○
visual decline	○	○

Gastrointestinal

None	Y	N
abdominal pain	○	○
belching	○	○
black stools	○	○
bloating	○	○
change in bowel habits	○	○
constipation	○	○
dairy intolerance	○	○
diarrhea	○	○
difficulty swallowing	○	○
flatulence	○	○
heartburn/indgestion	○	○
hemorrhoids	○	○
nausea	○	○
pain with bowel movement	○	○
rectal bleeding	○	○
rectal urgency/incontinence	○	○
vomiting	○	○
gas	○	○
jaundice	○	○
stomach cramps	○	○

Genitourinary

None	Y	N
blood in urine	○	○
urinary frequency	○	○
frequent urinary infections	○	○
kidney disease/failure	○	○
kidney stones	○	○
sexual difficulty	○	○
heavy periods	○	○
sexually transmitted diseases	○	○
Painful urination	○	○

Hematologic/Lymphatic

None	Y	N
easy bruising	○	○
prolonged bleeding	○	○
swollen glands	○	○

Integumentary

None	Y	N
dryness	○	○
hives	○	○
itching	○	○
lesions	○	○
rashes	○	○
jaundice	○	○

Musculoskeletal

None	Y	N
back pain	○	○
joint pain	○	○
muscle pain	○	○
arthritis	○	○
joint deformity	○	○
muscle weakness	○	○

Neurological

None	Y	N
dizziness	○	○
frequent headaches	○	○
numbness or tingling	○	○
fainting	○	○
migraine	○	○
seizures	○	○
tremors	○	○

Psychiatric

None	Y	N
anxiety/panic	○	○
depression	○	○
difficulty sleeping	○	○
inability to concentrate	○	○
loss of interest in enjoyable activites	○	○
suicidal thoughts	○	○

Respiratory

None	Y	N
COPD	○	○
asthma	○	○
excessive sputum	○	○

Immunizations

- [ ] None

- [ ] Influenza, seasonal, injectable — When:_____
- [ ] Pneumonia — When:_____
- [ ] Hepatitis A — When:_____
- [ ] Hepatitis B — When:_____
- [ ] TB/PPD — When:_____

Past or Present Medical Conditions

- [ ] None

- [ ] Anemia
- [ ] Arthritis
- [ ] Rheumatoid Arthritis
- [ ] Atrial Fibrilation
- [ ] Asthma
- [ ] Back Pain (chronic)
- [ ] Cancer (type) _____
- [ ] Cirrhosis
- [ ] Colon cancer
- [ ] Colon polyps
- [ ] Crohn's Disease
- [ ] Diabetes Mellitus
- [ ] Diverticulitis
- [ ] Diverticulosis
- [ ] Peptic Ulcer Disease
- [ ] Fatty Liver
- [ ] Gallstones
- [ ] Glaucoma
- [ ] Gout
- [ ] Heart Attack
- [ ] Hepatitis (type) _____
- [ ] High Blood Pressure
- [ ] HIV/AIDS
- [ ] Irregular Heart Beat
- [ ] IBS
- [ ] Kidney Disease
- [ ] Osteoporosis
- [ ] Pancreatitis
- [ ] Paralysis
- [ ] Parkinsons
- [ ] Pneumonia
- [ ] Reflux
- [ ] Rheumatic Fever
- [ ] Seizures
- [ ] STD (STI)
- [ ] Skin Cancer
- [ ] Stroke
- [ ] TB (Tuberculosis)
- [ ] TB Skin Test Positive
- [ ] Thyroid disorder
- [ ] Ulcerative Colitis
- [ ] Vascular Disease
- [ ] Other _____

Diagnostic Studies/Tests

- [ ] None

- [ ] Endoscopy — When:_____
- [ ] Colonoscopy — When:_____
- [ ] Sigmoidoscopy — When:_____
- [ ] Pacemaker — When:_____

Previous Procedures

- [ ] None

- [ ] Appendectomy
- [ ] Breast
- [ ] C-Section
- [ ] Cardiac Surgery
- [ ] Colon Resection
- [ ] ERCP
- [ ] Gallbladder Removed
- [ ] Hernia Repair
- [ ] Hemorrhoidectomy
- [ ] Hiatal Hernia Surgery
- [ ] Hysterectomy
- [ ] Joint Replacement
- [ ] Kidney
- [ ] Liver Biopsy
- [ ] Obesity Surgery
- [ ] Ovary Surgery
- [ ] Prostate
- [ ] Stomach
- [ ] Thyroid
- [ ] Tonsillectomy
- [ ] Tubal Ligation
- [ ] Other _____

Family Medical History

☐ No knowledge of family history

No family history of
☐ Colon cancer ☐ Colon Polyps
☐ Crohn's Disease ☐ Ulcerative Colitis

	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other
Health Status							
Healthy	○	○	○	○	○	○	○
	○	○	○	○	○	○	○
Deceased/At Age	____	____	____	____	____	____	____
Diagnoses							
Alcoholism	○	○	○	○	○	○	○
Cancer	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○
Heart Trouble	○	○	○	○	○	○	○
High Blood Pressure	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○
Lung Disease	○	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

Signature

Signature _____ Date _____