MIDDLESEX MONMOUTH GASTROENTEROLOGY

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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 ◯ 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

Allergies

- ◯ Patient has no known allergies
- ◯ Patient has no known drug allergies
- ◯ Aspirin
- ◯ Penicillins
- ◯ Codeine Sulfate
- ◯ Bactrim
- ◯ Sulfa (Sulfonamide Antibiotics)
- ◯ Milk
- ◯ Nsaids (Non-Steroidal Anti-Inflammatory Drug)
- ◯ Kiwi
- ◯ Eggs
- ◯ Peanuts
- ◯ Latex
- ◯ Band-Aids
- ◯ Iodine And Iodide Containing Products
- 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, adult — When: _____
- ◯ Hep B — When: _____
- ◯ HPV — When: _____
- ◯ Flu vaccine — When: _____
- ◯ MMR — When: _____
- ◯ Pneumococcal conjugate PCV 13 — When: _____
- ◯ tetanus toxoid — 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: _____
- ◯ Mammography — When: _____
- ◯ MRI Abdomen/Pelvis — When: _____
- ◯ Small Bowel Imaging — When: _____

Previous Procedures

- ◯ None
- ◯ Appendectomy When:_____
- ◯ C-Section When:_____
- ◯ Cardiac stent When:_____
- ◯ Colon Resection When:_____
- ◯ Gall Bladder Removal When:_____
- ◯ Hysterectomy When:_____
- ◯ Lung Bx When:_____
- ◯ Obesity Surgery When:_____
- ◯ Defibrillator When:_____
- ◯ Pacemaker When:_____

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:_____
- ◯ COPD 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:_____
- ◯ IBS 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
- ◯ Soft Drink
- ◯ Tea
- ◯ Chocolate
- ◯ Coffee

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

Exercise

◯ None

Type	Quantity	Number	Frequency

Drug Use

◯ None

◯ Recreational Drug Use

Type	Quantity	Number	Frequency