HATTIESBURG G.I. ASSOCIATES, PLLC

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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Notes:_____

Race

- ☐ White/Caucasian
- ☐ Black or African American
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Mixed
- ☐ Other
- ☐ Unknown
- ☐ Patient declines to provide information

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient declines to provide information

Gender

- ☐ Male
- ☐ Female
- ☐ Other

Preferred Language

- ☐ English
- ☐ Spanish
- Other:_____

Past or Present Medical Conditions

- ☐ None
- ☐ Acid Reflux
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer: Breast
- ☐ Cancer: Colon
- ☐ Cancer: Ovary
- ☐ Cancer: Prostate
- ☐ Cancer: Uterus
- ☐ Cancer: Other
- ☐ Chronic Kidney Disease
- ☐ Chronic Pain
- ☐ Cirrhosis of the Liver
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ Depression / Anxiety
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Elevated Cholesterol
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Heart Disease / Heart Attack
- ☐ Heart Murmurs
- ☐ Hepatitis
- ☐ High Blood Pressure (Hypertension)
- ☐ Irritable Bowel Syndrome (Spastic Colon)
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse/MR
- ☐ Pancreatitis
- ☐ Psychiatric Disorder
- ☐ Seizures
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Ulcerative Colitis

Previous Procedures

☐ None

☐ Appendectomy (appendix removed)
When:_____

☐ Back Surgery
When:_____

☐ Blood Transfusion
When:_____

☐ Colon (Large Intestine) Surgery
When:_____

☐ Coronary Artery (Heart) Stents
When:_____

☐ Episiotomy (stitches with childbirth)
When:_____

☐ Eye surgery
When:_____

☐ Gallbladder removed (Cholecystectomy)
When:_____

☐ Heart Surgery (Bypass or Valve Replacement)
When:_____

☐ Hemorrhoid Surgery
When:_____

☐ Hernia Repair
When:_____

☐ Hysterectomy (Ovaries Removed)
When:_____

☐ Hysterectomy (Ovaries NOT Removed)
When:_____

☐ Joint Surgery
When:_____

☐ Pacemaker (Cardiac) or Defibrillator Placement
When:_____

☐ Stomach Surgery
When:_____

☐ Tonsillectomy (tonsils removed)
When:_____

☐ Other
When:_____

Diagnostic Studies/Tests

☐ None

☐ CT Abd, Pelvis, Chest
When:_____

☐ Colonoscopy
When:_____

☐ EGD (Upper GI Endoscopy)
When:_____

☐ Liver Biopsy
When:_____

☐ Ultrasound (Abdomen &/Or Pelvis)
When:_____

☐ Other
When:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Alcohol

☐ None

Type	Quantity	Number	Frequency
☐ Beer			
☐ Wine			
☐ Liquor			

Tobacco

Smoking Status

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker
☐ Smoker, current status unknown ☐ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
☐ Cigarettes				
☐ Chewing Tobacco				

Family Medical History

☐ No knowledge of family history

Health Status	Mother	Father	Sister	Brother	Daughter	Son
Deceased/At Age	○ ____	○ ____	○ ____	○ ____	○ ____	○ ____
Cause of Death						
Diagnoses						
Cancer (Other)	○	○	○	○	○	○
Cancer: Colon or Rectal	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○
Colon or Rectal Polyps	○	○	○	○	○	○
Colitis (Ulcerative Colitis or Crohn's Disease)	○	○	○	○	○	○
Stomach Ulcers / Peptic Ulcer Disease	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○
Pancreatitis	○	○	○	○	○	○
Gallbladder Disease / Gallstones	○	○	○	○	○	○
High Blood Pressure (Hypertension)	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○
Stroke	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

Current Medications

☐ None

Name	Dose	How taken?

Review Of Systems

Constitutional
None

	Yes	No
fevers		
night sweats		
unintentional weight loss		
enlarged lymph nodes		
fatigue		
dizziness		
fainting		

Eyes
None

	Yes	No
recent change in vision		

ENMT
None

	Yes	No
persistent headaches		
impared hearing		
earache		
sore throat		
chronic sinus problems		
hoarseness		

Respiratory
None

	Yes	No
shortness of breath		
wheezing		
chronic cough		

Cardiovascular
None

	Yes	No
chest pain		
heart palpitations		
fluid retention		

Genitourinary
None

	Yes	No
pain or burning with urination		
difficulty in holding urine		
blood in urine		
awaken at night to urinate frequently		
Vaginal Discharge		
post-menopause		
are you pregnant?		
are you breastfeeding?		
tubal ligation		
prostate problems		
impotence		
burning or discharge from penis		
vasectomy		

Gastrointestinal
None

	Yes	No
abdominal pain		
abdominal bloating		
black, tarry stools		
blood in stool		
change in bowel habits		
constipation		
decreased appetite		
diarrhea		
esophaged reflux		
excessive belching		
excessive gas		
heartburn		
hemorrhoids		
nausea		
painful swallowing		
rectal pain		
rectal bleeding		
regurgitation of food or liquid		
take laxatives (regularly)		
trouble swallowing		
trouble with leaking of stool		
vomiting		

Neurological
None

	Yes	No
seizures		
numbness or tingling		
confusion		
weakness		

Psychiatric
None

	Yes	No
depression		
anxiety		
suicidal thoughts		

Endocrine
None

	Yes	No
heat or cold intolerance		
excessive thirst or urination		

Hematologic/Lymphatic
None

	Yes	No
abnormal bruising		
abnormal bleeding		
anemia		

Musculoskeletal
None

	Yes	No
joint pain		
joint swelling		
back pain		
muscle pain		

Integumentary
None

	Yes	No
skin rash		
skin itching		

Pharmacy

Name:_____

Signature

_____

Signature Date