Northland Gastroenterology, P.A.
1420 London Road, Suite 202, Duluth, MN 55805
P: 218-724-3411 • F: 218-724-3408
northlandgastro.com

# Patient Interview Form

## Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____

**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

☐ Other Race ☐ 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 ☐ Unknown

**Sex**

☐ Male ☐ Female ☐ Other ☐ Unknown

**Preferred Language**

☐ English ☐ Patient declines to specify

**Contact Preference**

☐ Letter ☐ Email ☐ Patient declines to specify Other:_____

## Pharmacy

Name Address Phone

## Allergies

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

☐ Adhesive Tape ☐ Codeine Sulfate ☐ Erythromycin ☐ Penicillins ☐ Shellfish

☐ Iv Dye, Iodine Containing ☐ Latex gloves Other: _____

## Current Medications

☐ None

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____

## Immunizations

☐ None

☐ Flu vaccine ☐ Hep A ☐ Hep B ☐ Pneumovax

## Diagnostic Studies/Tests

☐ None

☐ Colonoscopy When: _____ ☐ EGD When: _____ ☐ CT Abdomen/Pelvis When: _____ ☐ MRI Abdomen/Pelvis When: _____ ☐ ERCP When: _____

## Previous Procedures

☐ None

☐ Gallbladder removed ☐ Appendectomy ☐ Colon resection ☐ Small Bowel Resection ☐ Exploratory Laparoscopy

☐ Gastric Bypass ☐ Gastric Lap Band ☐ Hemorrhoidectomy ☐ Hemorrhoid banding ☐ Abdominoplasty

☐ Hysterectomy - Abdominal ☐ Bilateral Tubal Ligation (BTL) ☐ Mastectomy R Breast ☐ Pacemaker Insertion ☐ Defibrillator Placement

☐ Coronary Artery Bypass Graft (CABG) ☐ Abdominal aortic aneurysm (AAA) repair ☐ Heart valve replacement ☐ Cardiac Cath - with stent placement ☐ Joint Replacement

☐ Back Surgery ☐ Fibromyalgia Other: _____ Other: _____

## Past or Present Medical Conditions

☐ None

**Gastroenterology/Hepatology**

☐ Colon polyp history ☐ Colon cancer ☐ Irritable Bowel Syndrome

☐ Diverticulitis ☐ Crohn's Disease ☐ Ulcerative Colitis

☐ Gastroesophageal Reflux Disease (GERD) ☐ Barrett's Esophagus ☐ Ulcer Disease

☐ Hepatitis B ☐ Hepatitis C ☐ Fatty Liver

☐ Cirrhosis ☐ Celiac Disease ☐ Bowel Obstruction

☐ Pancreatitis ☐ Anemia Other: _____

Other: _____

**Cardiology**

☐ Coronary Artery Disease ☐ Congestive Heart Failure ☐ Heart Attack ☐ High blood pressure

☐ Atrial Fibrillation ☐ Vascular Disease ☐ High Cholesterol ☐ Stroke

☐ Transient Ischemic Attack ☐ Valvular heart disease ☐ Pacemaker ☐ Coronary Artery Stents

Other: _____ Other: _____

**Pulmonology**

- ◯ C.O.P.D.
- ◯ Asthma
- ◯ Sleep apnea
- ◯ Blood Clots (leg)
- ◯ Blood Clots (lung)
- ◯ Wheezing
- Other: _____
- Other: _____

**Other**

- ◯ Anxiety disorder
- ◯ Arthritis
- ◯ Bipolar disorder
- ◯ Breast cancer
- ◯ Current pregnancy
- ◯ Depression
- ◯ Diabetes Mellitus, Insulin Dependent (Type 1)
- ◯ Diabetes Mellitus, Non-Insulin Dependent (Type 2)
- ◯ Fibrositis / Fibromyalgia
- ◯ Gout
- ◯ HIV exposure
- ◯ HIV infection
- ◯ Hypothyroidism
- ◯ Kidney disease
- ◯ Kidney stones
- ◯ Lung cancer
- ◯ Ovarian Cancer
- ◯ Prostate Cancer
- ◯ Skin Cancer
- ◯ Seizures

## Social History

Occupation: _____ Number of Children: _____

**Marital Status**

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Separated
- ◯ Widowed
- ◯ Civil Union
- ◯ Unknown
- ◯ Other

**Alcohol**

- ◯ None
- ◯ Occasionally
- ◯ Daily

**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

| Type | Started | Quit | Quantity | Frequency |
|---|---|---|---|---|
| ◯ Cigarettes | | | | |
| ◯ Cigar | | | | |
| ◯ Chewing Tobacco | | | | |

**Caffeine**

- ◯ None
- ◯ Occasionally
- ◯ Daily

**Drug Use**

- ◯ None

| Type | Quantity | Number | Frequency Times / month |
|---|---|---|---|
| ◯ IV or intranasal drugs | | | |
| ◯ Other | | | |

**Exercise**

- ◯ None
- ◯ Regular exercise
- ◯ Occasional exercise

## Family Medical History

○ No knowledge of family history

**No family history of**

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

| **Health Status** | Mother | Father | Sister | Brother | Daughter | Son | Maternal Grandmother | Paternal Grandmother |
|---|---|---|---|---|---|---|---|---|
| Alive | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Deceased/At Age | ○ ____ | ○ ____ | ○ ____ | ○ ____ | ○ ____ | ○ ____ | ○ ____ | ○ ____ |
| Cause of Death | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| **Diagnoses** | | | | | | | | |
| Celiac Disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon polyps | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Crohn's disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Gallbladder disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Liver disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Ulcerative colitis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Other: | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

## Review Of Systems

**Allergic/Immunologic**

| ◯ None | Y | N |
|---|---|---|
| HIV exposure | ◯ | ◯ |
| persistent infections | ◯ | ◯ |
| strong allergic reaction | ◯ | ◯ |

**Cardiovascular**

| ◯ None | Y | N |
|---|---|---|
| chest pain | ◯ | ◯ |
| shortness of breath with exertion | ◯ | ◯ |
| irregular heart beat | ◯ | ◯ |
| orthopnea | ◯ | ◯ |
| palpitations | ◯ | ◯ |
| swelling in ankles | ◯ | ◯ |
| dizziness | ◯ | ◯ |

**Constitutional**

| ◯ None | Y | N |
|---|---|---|
| fatigue | ◯ | ◯ |
| fever | ◯ | ◯ |
| loss of appetite | ◯ | ◯ |
| malaise | ◯ | ◯ |
| sweats | ◯ | ◯ |
| weight gain | ◯ | ◯ |
| inadvertent 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 | ◯ | ◯ |
| yellow skin/eyes | ◯ | ◯ |
| nausea | ◯ | ◯ |
| rectal bleeding | ◯ | ◯ |
| stomach cramps | ◯ | ◯ |
| vomiting | ◯ | ◯ |
| difficulty swallowing | ◯ | ◯ |

**Genitourinary**

| ◯ None | Y | N |
|---|---|---|
| dark urine | ◯ | ◯ |
| decrease in urine flow | ◯ | ◯ |
| frequent urinary infections | ◯ | ◯ |
| frequent urination | ◯ | ◯ |
| impotence | ◯ | ◯ |
| urethral discharge or incontinence | ◯ | ◯ |

**Hematologic/Lymphatic**

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

**Integumentary**

| ◯ None | Y | N |
|---|---|---|
| hives | ◯ | ◯ |
| itching | ◯ | ◯ |
| lesions | ◯ | ◯ |
| rashes | ◯ | ◯ |

**Musculoskeletal**

| ◯ None | Y | N |
|---|---|---|
| arthritis | ◯ | ◯ |
| back pain | ◯ | ◯ |
| gout | ◯ | ◯ |
| joint deformity | ◯ | ◯ |
| joint pain | ◯ | ◯ |
| muscle weakness | ◯ | ◯ |
| stiffness | ◯ | ◯ |

**Neurological**

| ◯ None | Y | N |
|---|---|---|
| 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 | ◯ | ◯ |
| excessive sputum | ◯ | ◯ |
| coughing up blood | ◯ | ◯ |
| shortness of breath with exercise | ◯ | ◯ |
| wheezing | ◯ | ◯ |

## Consent to Import Medication History

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

◯ 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