Charles M. Schron, M.D.
G. Alan Bracher, M.D.
Manish G. Amin, M.D.
Sandeep C. Patel, M.D.
Yatin R. Patel, M.D.

SEVG
SOUTHEAST VALLEY GASTRO
Chandler Gilbert Casa Grande
WWW.SEVGASTRO.COM

Christina F. Sloan, PA-C
Molly A. Wyant, PA-C
Jessica S. Laurino, PA-C
Jennifer L. Spohn, PA-C
PHONE: 480-899-9800

# 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

**Ethnicity**

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify

**Sex**

☐ Male ☐ Female ☐ Other

**Preferred Language**

☐ English ☐ Patient declines to specify Other:_____

## Allergies

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

☐ Codeine ☐ Penicillins ☐ Iodine ☐ Latex ☐ Sulfa (Sulfonamide Antibiotics)

Other:_____

## Current Medications

☐ None

| Name | Dose | How taken? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Immunizations

- [ ] None

- [ ] PPD When:
- [ ] Hep A When:
- [ ] Hep B When:
- [ ] Pneumovax When:
- Other:

## Diagnostic Studies/Tests

- [ ] None

- [ ] Colonoscopy When:
- [ ] Endoscopy (EGD) When:
- [ ] Abdominal CT When:
- [ ] Abdominal MRI When:
- [ ] Pelvic MRI When:
- [ ] Pelvic CT When:
- [ ] Abdominal U/S When:
- [ ] Pelvic Ultrasound When:
- [ ] Barium enema x-ray When:
- [ ] Barium swallow x-ray When:
- [ ] Cardiac catheterization When:
- [ ] Echocardiagram When:
- [ ] DEXA When:
- Other:

## Past or Present Medical Conditions

- [ ] None

**GI**

- [ ] Colon polyps When:
- [ ] Acid reflux When:
- [ ] Duodenal ulcer When:
- [ ] Stomach ulcer When:
- [ ] Barrets esophagus When:
- [ ] Gallstones When:
- [ ] Ulcerative colitis When:
- [ ] Crohn's disease When:
- [ ] Hepatitis C When:
- [ ] Hepatitis B When:
- [ ] Irritable bowel syndrome When:
- Other:
- Other:

**Rheumatology/ Hematology**

- [ ] Osteoarthritis When:
- [ ] Rheumatoid arthritis When:
- [ ] Fibromyalgia When:
- [ ] Anemia/iron deficiency When:
- [ ] Osteoporosis When:
- [ ] Bleeding disorder When:

**Heart/Lung**

- [ ] Coronary artery disease When:
- [ ] Heart attack When:
- [ ] Congestive heart hailure When:
- [ ] Valvular heart disease When:
- [ ] Atrial fibrillation When:
- [ ] Pacemaker When:
- [ ] Defibrillator When:
- [ ] High blood pressure When:
- [ ] High cholesterol When:
- [ ] Stroke When:
- [ ] Asthma When:
- [ ] C.O.P.D. When:
- [ ] Sleep apnea When:
- [ ] Tuberculosis (TB) When:
- [ ] Valley Fever When:

**Endocrine/ Metabolic/Misc**

- [ ] Diabetes When:
- [ ] Hypothyroidism When:
- [ ] Hyperthyroidism When:
- [ ] Kidney Disease When:

| | | | | |
|---|---|---|---|---|
| | ☐ Kidney stones<br>When:_____<br>When:_____ | ☐ Seizures<br>When:_____<br>☐ Bipolar disorder<br>When:_____ | ☐ Glaucoma<br>When:_____<br>☐ Anxiety disorder<br>When:_____ | ☐ Headaches<br>When:_____ |
| **Cancer** | ☐ Colon cancer<br>When:_____<br>☐ Lung cancer<br>When:_____ | ☐ Prostate Cancer<br>When:_____<br>Other:_____ | ☐ Breast cancer<br>When:_____ | ☐ Skin Cancer<br>When:_____ |

## Previous Procedures

☐ None

| | | | | |
|---|---|---|---|---|
| ☐ Appendectomy<br>When:_____ | ☐ Bowel Resection<br>When:_____ | ☐ Anti-reflux surgery<br>When:_____ | ☐ Hernia Repair<br>When:_____ | ☐ Gastric Bypass<br>When:_____ |
| ☐ Lap band<br>When:_____ | ☐ Splenectomy<br>When:_____ | ☐ Tonsillectomy<br>When:_____ | ☐ Thyroidectomy<br>When:_____ | ☐ Lumpectomy breast<br>When:_____ |
| ☐ Heart valve replacement<br>When:_____ | ☐ Cardiac stent<br>When:_____ | ☐ Coronary artery bypass surgery<br>When:_____ | ☐ Lung surgery<br>When:_____ | ☐ Hysterectomy<br>When:_____ |
| ☐ Ovaries removed<br>When:_____ | ☐ Ovary surgery<br>When:_____ | ☐ TURP<br>When:_____ | ☐ Prostatectomy<br>When:_____ | ☐ Vasectomy<br>When:_____ |
| ☐ Back Surgery<br>When:_____ | ☐ Vascular Surgery<br>When:_____ | ☐ Tubal Ligation<br>When:_____ | ☐ Hip Replacement (left)<br>When:_____ | ☐ Hip Replacement (right)<br>When:_____ |
| ☐ Knee Replacement (left)<br>When:_____ | ☐ Knee replacement (right)<br>When:_____ | ☐ Hemorrhoid surgery<br>When:_____ | ☐ Gallbladder removal<br>When:_____ | ☐ Colon resection<br>When:_____ |
| ☐ Mastectomy<br>When:_____ | Other:_____ | Other:_____ | | |

## Social History

Occupation:_____ Number of Children:_____

**Marital Status**

| | | | | |
|---|---|---|---|---|
| ☐ Single | ☐ Married | ☐ Divorced | ☐ Separated | ☐ Widowed |
| ☐ Civil Union | ☐ Unknown | ☐ Other | | |

**Alcohol**

☐ None

| Type | Quantity | Number | Frequency |
|---|---|---|---|
| | | | |

**Caffeine**

☐ None

Intake:_____ Intake:_____

**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 |
|---|---|---|---|---|
| ○ Chewing Tobacco | | | | |
| ○ Smokeless | | | | |

**Drug Use**

○ None

| Type | Quantity | Number | Frequency |
|---|---|---|---|
| | | | |

**Exercise**

○ None

| Type | Quantity | Number | Frequency |
|---|---|---|---|
| | | | |

## Family Medical History

○ No knowledge of family history

**No family history of** ○ Colon cancer ○ Polyps

| | Mother | Father | Sister | Brother | Daughter | Son | Maternal Grandfather | Maternal Grandmother | Paternal Grandfather | Paternal Grandmother | Maternal Aunt | Maternal Uncle | Paternal Aunt | Paternal Uncle |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Diagnoses** | | | | | | | | | | | | | | |
| Colon cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon polyps | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Liver cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Esophagus Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Stomach Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Pancreas Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Ovarian Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Uterine Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Breast Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Kidney Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Prostate Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Crohn's Disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Ulcerative Colitis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Liver Disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Pancreatitis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Irritable Bowel Syndrome | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Heart Disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Eating Disorders | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Alcoholism | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Bleeding Disorders | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon Cancer Primary malignant neoplasm | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

Other:

## Review Of Systems

**Constitutional**

| None | Y | N |
|---|---|---|
| loss of appetite | ○ | ○ |
| excessive appetite | ○ | ○ |
| fatigue | ○ | ○ |
| difficulty sleeping | ○ | ○ |
| lack of exercise | ○ | ○ |
| excessive sweating | ○ | ○ |
| weight gain | ○ | ○ |
| weight loss | ○ | ○ |
| fever | ○ | ○ |

**ENMT**

| None | Y | N |
|---|---|---|
| blurred vision | ○ | ○ |
| double vision | ○ | ○ |
| eye pain - itchy watery eyes | ○ | ○ |
| cataracts | ○ | ○ |
| loss of hearing | ○ | ○ |
| ear pain | ○ | ○ |
| ringing in ears | ○ | ○ |
| dental problems | ○ | ○ |
| sore tongue | ○ | ○ |
| taste changes | ○ | ○ |
| swelling of gums | ○ | ○ |
| sore throat | ○ | ○ |

**Respiratory**

| None | Y | N |
|---|---|---|
| chronic cough | ○ | ○ |
| productive cough | ○ | ○ |
| coughs up blood | ○ | ○ |
| chronic bronchitis | ○ | ○ |
| sleep apnea | ○ | ○ |
| shortness of breath with exercise | ○ | ○ |

**Cardiovascular**

| None | Y | N |
|---|---|---|
| palpitations | ○ | ○ |
| angina | ○ | ○ |
| dizziness | ○ | ○ |
| shortness of breath with activity | ○ | ○ |
| elevated on 2 or more pillows to breathe at night | ○ | ○ |
| swelling of feet/ankles | ○ | ○ |
| heart murmur | ○ | ○ |
| chest pain | ○ | ○ |

**Gastrointestinal**

| None | Y | N |
|---|---|---|
| heartburn | ○ | ○ |
| difficulty swallowing | ○ | ○ |
| bloating | ○ | ○ |
| belching | ○ | ○ |
| nausea | ○ | ○ |
| vomiting | ○ | ○ |
| vomiting blood | ○ | ○ |
| abdominal pain | ○ | ○ |
| constipation | ○ | ○ |
| diarrhea | ○ | ○ |
| stool urgency | ○ | ○ |
| black stools | ○ | ○ |
| rectal bleeding | ○ | ○ |
| pain in rectum | ○ | ○ |
| incontinence of stools | ○ | ○ |
| change in bowel habits | ○ | ○ |

**Musculoskeletal**

| None | Y | N |
|---|---|---|
| joint pain | ○ | ○ |
| muscle aches | ○ | ○ |
| back pain | ○ | ○ |
| joint swelling | ○ | ○ |
| joint pain from arthritis | ○ | ○ |

**Genitourinary**

| None | Y | N |
|---|---|---|
| nocturia | ○ | ○ |
| hematuria | ○ | ○ |
| urgency | ○ | ○ |
| difficulty starting urine | ○ | ○ |
| burning on urination | ○ | ○ |
| urinary incontinence | ○ | ○ |
| weak urine stream | ○ | ○ |
| prostate problems | ○ | ○ |
| lumps or masses on testicles | ○ | ○ |
| discharge from penis | ○ | ○ |
| painful testicles | ○ | ○ |
| menstral problems | ○ | ○ |
| breakthrough bleeding | ○ | ○ |
| breasts implants | ○ | ○ |
| breast lump | ○ | ○ |
| excessive vaginal bleeding | ○ | ○ |
| postmenopausal | ○ | ○ |
| hot flashes | ○ | ○ |
| blood with intercourse | ○ | ○ |
| premenstrual tension | ○ | ○ |

**Integumentary**

| None | Y | N |
|---|---|---|
| chronic skin condition | ○ | ○ |
| recent rash | ○ | ○ |
| excessive itching | ○ | ○ |
| acne | ○ | ○ |

**Neurological**

| None | Y | N |
|---|---|---|
| dizziness | ○ | ○ |
| lightheadedness | ○ | ○ |
| vertigo | ○ | ○ |
| numbness or tingling | ○ | ○ |
| tremors | ○ | ○ |
| seizures | ○ | ○ |
| traumatic brain injury | ○ | ○ |

**Psychiatric**

| None | Y | N |
|---|---|---|
| difficulty making decisions | ○ | ○ |
| lack of concentration | ○ | ○ |
| depression | ○ | ○ |
| cries often | ○ | ○ |
| worries excessively | ○ | ○ |
| panic attacks | ○ | ○ |
| memory loss | ○ | ○ |
| desires psychiatric help | ○ | ○ |
| anxiety | ○ | ○ |

**Hematologic/Lymphatic**

| None | Y | N |
|---|---|---|
| bleeds easily | ○ | ○ |
| bruises easily | ○ | ○ |
| swollen lymph nods in neck, armpits, groin | ○ | ○ |

**Endocrine**

| None | Y | N |
|---|---|---|
| excessive thirst | ○ | ○ |
| hair loss | ○ | ○ |
| heat or cold intolerance | ○ | ○ |

**Allergic/Immunologic**

| None | Y | N |
|---|---|---|
| HIV exposure | ○ | ○ |
| immunodeficiency disorder | ○ | ○ |
| urticaria/hives | ○ | ○ |

## Pharmacy

Name | Address | Phone

## 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