Southeast Valley Gastroenterology Consultants, P.C. (SEVG)

PATIENT INTERVIEW FORM

First Name:_____ **Last Name:**_____

Date of Birth (MM/DD/YYYY): _____

Contact Preference: ☐ Email ☐ Text ☐ Phone ☐ Other_____

Preferred Language: ☐ English ☐ Other _____

I would like to receive preventive care and follow up care reminders. ☐ Yes ☐ No

Medication History:

I consent to obtaining a history of my medications purchased at pharmacies. ☐ Yes ☐ No

Local Pharmacy:_____ **Street Address**:_____

Current Prescription Medications:

Name **Dose** **How taken? (Ex: once daily)**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you take any of the following over-the-counter medications or supplements?

☐	Famotidine (Pepcid AC)	Dose-	How Often-	☐	Aspirin (Excedrin)	Dose-	How Often-
☐	Tagamet (Cimetidine)	Dose-	How Often-	☐	Naproxen (Alleve)	Dose-	How Often-
☐	Ibuprofen (Advil)	Dose-	How Often-	☐	Other:	Dose-	How Often-
☐	Calcium	Dose-	How Often-	☐	Vitamin D	Dose-	How Often-
☐	Iron	Dose-	How Often-	☐	Magnesium	Dose-	How Often-

Allergies: (*Please check ☑ all that apply)* ☐ **I have No Known Drug Allergies**

Latex ☐ Reaction:_____
IV Contrast ☐ Reaction:_____
Iodine ☐ Reaction:_____
Other- _____
Other- _____

Immunizations: (*Please check ☑ all that apply and note the date)*

☐	Flu	When: MM/YYYY	☐	COVID-19	When: MM/YYYY
☐	Hepatitis A	When: MM/YYYY			
☐	Hepatitis B	When: MM/YYYY			
☐	Pneumovax	When: MM/YYYY			

Past or Present Medical Conditions:

(*Please check all that apply)*

GI Conditions:

☐	Colon Polyps	☐	Ulcerative Colitis
☐	Acid Reflux	☐	Crohn's Disease
☐	Duodenal Ulcer	☐	Hepatitis C
☐	Stomach Ulcer	☐	Hepatitis B
☐	Barrett's Esophagus	☐	Irritable Bowel Syndrome
☐	Gallstones	☐	Celiac Disease
☐	Other:	☐	Other:

Rheumatology/Hematology:

☐	Osteoarthritis	☐	Clotting Disorder
☐	Rheumatoid Arthritis	☐	Osteoporosis
☐	Fibromyalgia	☐	Osteopenia
☐	Anemia/Iron Deficiency	☐	Other

Heart/Lung:

☐	Coronary Artery Disease	☐	High Cholesterol
☐	Heart Attack	☐	Stroke
☐	Congestive Heart Failure	☐	Asthma
☐	Valvular Heart Disease	☐	Sleep Apnea
☐	Atrial Fibrillation	☐	COPD
☐	Pacemaker	☐	Valley Fever
☐	Defibrillator	☐	Other:
☐	High Blood Pressure	☐	Other:

Endocrine/Metabolic/Misc.:

☐	Diabetes	☐	Glaucoma	☐	Psoriasis
☐	Hypothyroidism (Under)	☐	Migraines	☐	Other:
☐	Hyperthyroidism (Over)	☐	Depression	☐	Other:
☐	Kidney Disease	☐	Anxiety Disorder	☐	Other:
☐	Kidney Stones	☐	HIV	☐	Other:
☐	Seizures	☐	Dementia	☐	Other:

Cancer:

☐	Colon Cancer	☐	Skin Cancer	When: MM/YYYY
☐	Prostate Cancer	☐	Lung Cancer	When: MM/YYYY
☐	Breast Cancer	☐	Other:	When: MM/YYYY

Diagnostic Studies:

☐	Colonoscopy	When: MM/YYYY	☐	Cardiac Catheterization	When: MM/YYYY
☐	Upper Endoscopy	When: MM/YYYY	☐	Echocardiogram	When: MM/YYYY
☐	Other:	When: MM/YYYY	☐	Other:	When: MM/YYYY

Surgical History: (*Please check all that apply)*

	Appendectomy	When: MM/YYYY		Cardiac Stent	When: MM/YYYY
	Anti-Reflux Surgery	When: MM/YYYY		Coronary Artery Bypass	When: MM/YYYY
	Gastric Bypass	When: MM/YYYY		Aortic Valve Replacement	When: MM/YYYY
	Lap Band	When: MM/YYYY		Mitral Valve Replacement	When: MM/YYYY
	Gallbladder Removal	When: MM/YYYY		Hip Replacement	When: MM/YYYY L or R
	Tonsillectomy	When: MM/YYYY		Knee Replacement	When: MM/YYYY L or R
	Colon Resection	When: MM/YYYY		C-Section	When: MM/YYYY
	Small Bowel Resection	When: MM/YYYY		Hysterectomy	When: MM/YYYY
	Inguinal hernia Repair	When: MM/YYYY		Mastectomy	When: MM/YYYY L or R
	Umbilical hernia Repair	When: MM/YYYY		Other:	When: MM/YYYY
	Incisional Hernia Repair	When: MM/YYYY		Other:	When: MM/YYYY
	Hemorrhoid Surgery	When: MM/YYYY		Other:	When: MM/YYYY

Family Medical History: (*Please check all family members that apply)*

Diagnosis	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle
Colon Cancer														
Colon Polyps														
Liver Cancer														
Esophagus Cancer														
Stomach Cancer														
Pancreas Cancer														
Ovarian Cancer														
Uterine Cancer														
Kidney Cancer														
Crohn's Disease														
Ulcerative Colitis														
Celiac Disease														
Alcoholism														
Liver Disease														
Lynch Syndrome (HNPCC)														
Familial Adenomatous Polyposis Syndrome														
Other:														
Other:														
Other:														
Other:														

Social History:

Occupation:_____ Retired? ☐ Yes ☐ No

Number of Children:_____

Marital Status: (*Please check the one that applies)*

☐ Single ☐ Married ☐ Widowed

Alcohol: ☐ None

Drink Type _____ How Many_____ Per: Day / Week / Month / Year

Tobacco: ☐ Every Day Smoker ☐ Some Day Smoker ☐ Former Smoker ☐ Never Smoker

Tobacco Type _____ How Many_____ Per: Day / Week / Month / Year

Illicit Drug Use: ☐ None

Drug Type _____ How Many_____ Per: Day / Week / Month / Year

Marijuana/Cannabis Use: ☐ None

Route (Smoke/Edible) _____ How Many_____ Per: Day / Week / Month / Year

Review of Symptoms: (Please check all that apply)

Constitutional

- ☐ loss of appetite
- ☐ memory loss
- ☐ fatigue
- ☐ difficulty sleeping
- ☐ excessive sweating
- ☐ weight gain
- ☐ weight loss
- ☐ fever

Cardiovascular

- ☐ palpitations
- ☐ fainting
- ☐ dizziness
- ☐ shortness of breath with activity
- ☐ swelling of feet/ankles
- ☐ heart murmur
- ☐ chest pain

Gastrointestinal

- ☐ heartburn
- ☐ difficulty swallowing
- ☐ bloating
- ☐ belching
- ☐ nausea
- ☐ vomiting
- ☐ vomiting blood
- ☐ abdominal pain
- ☐ constipation
- ☐ diarrhea
- ☐ stool urgency
- ☐ black stools
- ☐ rectal bleeding
- ☐ pain in rectum
- ☐ incontinence of stool
- ☐ change in bowel habits

Musculoskeletal

- ☐ joint pain
- ☐ muscle aches
- ☐ back pain
- ☐ joint swelling

Psychiatric

- ☐ depression
- ☐ cries often
- ☐ worries excessively
- ☐ panic attacks
- ☐ anxiety

Respiratory

- ☐ chronic cough
- ☐ productive cough
- ☐ coughs up blood
- ☐ shortness of breath