Gastroenterology Specialists
Diplomate, American Board Internal Medicine and Gastroenterology

Steven A. Meckstroth, M.D.
Manuel F. Bustamante, M.D.
William Gonzalez, PA-C
Karina Hooper, PA-C

Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

MRN: _____ 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: _____

Contact Preference

- ◯ Letter
- ◯ Mobile Phone
- ◯ Home Phone
- ◯ Other: _____

Allergies

- ◯ Patient has no known allergies
- ◯ Patient has no known drug allergies
- ◯ Codeine Sulfate
- ◯ Penicillins
- ◯ Sulfa (Sulfonamide Antibiotics)
- ◯ Other _____
- ◯ Anesthesia

Current Medications

- ◯ None

Name	Dose	How taken?

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Immunizations

- ◯ None
- ◯ Hep A, adult
- ◯ Hep B, adult

Diagnostics Studies/Tests

- ◯ None

Past or Present Medical Conditions

- ◯ None
- ◯ Anemia
- ◯ Cirrhosis
- ◯ Colitis
- ◯ Colon cancer
- ◯ Colon polyps
- ◯ Crohn's Disease
- ◯ Pancreatitis
- ◯ Diabetes Mellitus
- ◯ Diverticulitis
- ◯ Diverticulosis
- ◯ Duodenal Ulcer
- ◯ Fatty Liver
- ◯ Gallstones
- ◯ Hepatitis
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ Hiatal hernia
- ◯ IBS
- ◯ Lactose Intolerance
- ◯ Kidney Stones
- ◯ Glaucoma
- ◯ Stomach Ulcer
- ◯ Ulcerative Colitis
- ◯ Asthma
- ◯ Atrial Fibrillation
- ◯ Back Pain (chronic)
- ◯ Breast cancer
- ◯ Skin cancer
- ◯ Chronic Lung Disease
- ◯ Congestive Heart Failure
- ◯ Depression
- ◯ Emphysema
- ◯ Stroke
- ◯ Lupus
- ◯ Gout
- ◯ Heart Attack
- ◯ Heart Murmurs
- ◯ High Blood pressure
- ◯ High Cholesterol
- ◯ High Triglycerides
- ◯ History of Suicide Attempt
- ◯ Irregular Heart Beat
- ◯ Chronic Kidney Disease
- ◯ Kidney Failure
- ◯ TB exposure
- ◯ Migraines
- ◯ Osteoarthritis
- ◯ Paralysis
- ◯ Parkinsons
- ◯ Pneumonia
- ◯ Rheumatic Fever
- ◯ Rheumatoid arthritis
- ◯ Seizures
- ◯ Uterine cancer
- ◯ Sleep apnea
- ◯ Thyroid disorder
- ◯ Other _____

Previous Procedures

- ◯ None
- ◯ Colonoscopy
- ◯ EGD
- ◯ Adenoidectomy
- ◯ C-Section
- ◯ Cardiac Surgery
- ◯ Gallbladder removed
- ◯ Hysterectomy
- ◯ Joint Surgery
- ◯ Prostatectomy
- ◯ Thyroidectomy
- ◯ Tonsillectomy
- ◯ Pacemaker
- ◯ Nephrectomy
- ◯ Gastric By-pass
- ◯ Gastric Band
- ◯ Breast Augmentation
- ◯ Liver Biopsy
- ◯ Hemorrhoidectomy
- ◯ Coronary artery bypass surgery

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Social History

Occupation: _____ Number of Children: _____

Marital Status

◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Alcohol

◯ None

Type	Quantity	Number	Frequency

Tobacco

Smoking Status

◯ Current every day smoker ◯ Current some day smoker ◯ Former smoker ◯ Never smoker

◯ Smoker, current status unknown ◯ Unknown if ever smoked

Drug Use

◯ None

Type	Quantity	Number	Frequency
◯ Narcotics			
◯ Other			

Exercise

◯ None

◯ I walk ◯ I jog ◯ I Bike ◯ I Golf ◯ Tennis

◯ Lift Weights ◯ I swim ◯ I do aerobics

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Family Medical History

◯ No knowledge of family history

No family history of ◯ Colon cancer ◯ Polyps

	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Other	Unknown
Diagnoses										
Colon Cancer	O	O	O	O	O	O	O	O	O	O
Colon Polyps	O	O	O	O	O	O	O	O	O	O
Ulcerative colitis, unspecified	O	O	O	O	O	O	O	O	O	O
Crohn's Disease	O	O	O	O	O	O	O	O	O	O
Diabetes	O	O	O	O	O	O	O	O	O	O
Cancer, specify_____	O	O	O	O	O	O	O	O	O	O
Esophageal Cancer	O	O	O	O	O	O	O	O	O	O
Impaired gallbladder function	O	O	O	O	O	O	O	O	O	O
Heart Trouble	O	O	O	O	O	O	O	O	O	O
Liver Cancer	O	O	O	O	O	O	O	O	O	O
Liver Disease	O	O	O	O	O	O	O	O	O	O
Pancreas Disease/Cancer	O	O	O	O	O	O	O	O	O	O
Stomach Cancer	O	O	O	O	O	O	O	O	O	O
Ulcer Disease	O	O	O	O	O	O	O	O	O	O
Irritable bowel syndrome	O	O	O	O	O	O	O	O	O	O

Review of Systems

Allergic/Immunologic		
◯ None	**Yes**	**No**
HIV Exposure	O	O
persistent infections	O	O
strong allergic reactions or urticarial	O	O

Cardiovascular		
◯ None	**Yes**	**No**
chest pain	O	O
dyspnea with exercise	O	O
irregular heart beat	O	O
orthopnea	O	O

Gastrointestinal		
◯ None	**Yes**	**No**
abdominal swelling	O	O
change in bowel habits	O	O
Constipation	O	O
Diarrhea	O	O
Gas	O	O
Heartburn	O	O
Jaundice	O	O
Nausea	O	O
rectal bleeding	O	O
stomach cramps	O	O

Integumentary		
◯ None	**Yes**	**No**
allergies	O	O
dryness	O	O
hives	O	O
itching	O	O
jaundice	O	O
lesions	O	O
rashes	O	O

Musculoskeletal		
◯ None	**Yes**	**No**

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palpitations	O	O
peripheral edema	O	O
syncope	O	O

Constitutional

◯ None	Yes	No
fatigue	O	O
fever	O	O
loss of appetite	O	O
malaise	O	O
sweats	O	O
weight gain	O	O
weight loss	O	O

ENMT

◯ None	Yes	No
difficulty swallowing	O	O
dizziness	O	O
ear pain	O	O
nasal obstruction	O	O
nose bleeds	O	O
sore throat	O	O
hearing loss	O	O

Endocrine

◯ None	Yes	No
excessive thirst	O	O
hair loss	O	O
heat intolerance	O	O

Eyes

◯ None	Yes	No
double vision	O	O
loss of vision	O	O
photophobia	O	O

Vomiting	O	O
difficulty swallowing	O	O
Dyspepsia	O	O
abdominal pain upper	O	O
abdominal pain lower	O	O
anal/rectal pain	O	O
Belching	O	O
black stools	O	O
Bloating	O	O
dairy intolerance	O	O
Hemorrhoids	O	O
mucus in stool	O	O
pain with bowel movement	O	O
rectal urgency	O	O
Reflux	O	O
soiling stool/incontinence	O	O
weight loss less than 10lbs	O	O
weight loss more than 10lbs	O	O
weight gain less than 10lbs	O	O
weight gain more than 10lbs	O	O

Genitourinary

◯ None	Yes	No
dark urine	O	O
decrease in urine flow	O	O
Dysuria	O	O
frequent urinary infections	O	O
frequent urination	O	O
Hematuria	O	O
Impotence	O	O
Nocturia	O	O
urethral discharge or incontinence	O	O

Hematologic/Lymphatic

◯ None	Yes	No
bleeding gums or palpable lymph Nodes	O	O
easy bruising	O	O
prolonged bleeding	O	O

arthritis	O	O
back pain	O	O
gout	O	O
joint deformity	O	O
joint pain	O	O
muscle weakness	O	O
stiffness	O	O

Neurological

◯ None	Yes	No
dizziness	O	O
fainting	O	O
frequent headaches	O	O
migraine	O	O
numbness or tingling	O	O
seizures	O	O
tremors	O	O
vertigo	O	O
memory loss	O	O

Psychiatric

◯ None	Yes	No
anxiety	O	O
depression	O	O
difficulty sleeping	O	O
hallucinations	O	O
nervousness	O	O
panic attacks	O	O
paranoia	O	O

Reparatory

◯ None	Yes	No
asthma	O	O
dyspnea	O	O
excessive sputum	O	O
coughing up blood	O	O
shortness of breath w/exercise	O	O
wheezing	O	O

PHARMACY _____

Name: _____