OhioGastro
Ohio Gastroenterology Group, Inc.

North Office	3400 Olentangy River Rd. .....Columbus, Ohio 43202
East Office	85 McNaughten Rd., Suite 320.....Columbus, Ohio 43213
West Office	815 West Broad St., Suite 220 .....Columbus, Ohio 43222
Dublin Office	6670 Perimeter Dr., Suite 200 .....Dublin, Ohio 43016
Westerville Office	450 Alkyre Run Drive, Suite 350.....Westerville, Ohio 43082

T. (614) 754-5500 ..... F. (614) 754-5501

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

MRN:_____ Date Of Birth:_____

Age:_____ Notes:_____

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 ☐ French ☐ Japanese ☐ Russian ☐ Patient declines to specify

Family Medical History

☐ No knowledge of family history

No family history of ☐ Colon Cancer ☐ No Family History of Colon Polyps

	Father	Mother	Brother	Sister	Grandfather	Grandmother	Other
Diagnoses							
Crohn's	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○

Gall Bladder Disease	○	○	○	○	○	○	○
Heart Trouble	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○
Pancreatitis	○	○	○	○	○	○	○
Gastric Ulcer	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○

Pharmacy

Name Address Phone

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Codeine Sulfate
- ☐ Penicillins
- ☐ Demerol
- ☐ Latex
- ☐ Adhesive Tape
- ☐ Versed
- ☐ Aspirin (Tartrazine Only)
- ☐ Propofol
- ☐ Iodinated Contrast Media - Iv Dye
- ☐ fentanyl citrate
- ☐ morphine

Other: Other: Other:

Current Medications

- ☐ None

Name	Dose

Immunizations

- ☐ None
- ☐ DTaP/Tetanus When:_____
- ☐ Hep A When:_____
- ☐ Hep B When:_____
- ☐ Influenza, seasonal, injectable When:_____
- ☐ Pneumonia When:_____
- ☐ PPD When:_____
- ☐ Measles/Mumps When:_____
- ☐ Varicella/Chicken Pox When:_____
- Other:_____
- Other:_____

Diagnostic Studies/Tests

- ☐ None
- ☐ EGD When:_____
- ☐ Colonoscopy When:_____
- ☐ CT Abdomen When:_____
- ☐ Abdominal Ultrasound When:_____
- ☐ MRI Abdomen When:_____
- ☐ Mammogram When:_____
- Other:_____

Previous Procedures

- ☐ None
- ☐ Automatic Defibrillator Placement
- ☐ Colon/Bowel Surgery
- ☐ Gallbladder
- ☐ Stomach Surgery
- ☐ Heart Bypass
- ☐ Heart Stent
- ☐ Heart Valve
- ☐ Hemorrhoids
- ☐ Hysterectomy
- ☐ Pacemaker Insertion
- ☐ Reflux Surgery
- ☐ Obesity Surgery
- Other:_____
- Other:_____
- Other:_____

Past or Present Medical Conditions

- ☐ None
- ☐ Anesthesia complication
- ☐ Acid Reflux
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding/Clotting Disorder
- ☐ Cancer
- ☐ Chronic Lung Disease
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ Depression/ Anxiety
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Endocarditis (Heart Valve Infection)
- ☐ Fatty Liver
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hiatal Hernia
- ☐ Heart Murmur
- ☐ High blood pressure
- ☐ History of Suicide Attempts
- ☐ HIV/AIDS
- ☐ Irregular Heart Beat
- ☐ Irritable Bowel Syndrome
- ☐ Ischemic Heart Disease
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Neck or Jaw Injury
- ☐ Osteoarthritis
- ☐ Pancreatitis
- ☐ Parkinsons
- ☐ Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Skin Cancer
- ☐ Sleep Apnea/ CPAP
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ TB (Tuberculosis)
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis
- Other:_____
- Other:_____
- 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:_____

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

Drug Use

☐ None

Type Quantity Number Frequency

Exercise

☐ None

Type:_____ Type:_____

☐ Ambulates Independently ☐ Walks with Cane ☐ Walks with Walker ☐ Uses Wheelchair ☐ Requires Transport or Ambulance

Review Of Systems

Allergic/Immunologic

◯ None	Y	N
HIV exposure	◯	◯
persistent infections	◯	◯
strong allergic reactions or urticaria	◯	◯

Cardiovascular

◯ None	Y	N
chest pain	◯	◯
shortness of breath with exercise	◯	◯
irregular heart beat	◯	◯
leg or ankle swelling	◯	◯
shortness of breath with lying down	◯	◯
fast or irregular heart beating	◯	◯
shortness of breath	◯	◯
fainting or passing out	◯	◯

Constitutional

◯ None	Y	N
fatigue	◯	◯
fever	◯	◯
loss of appetite	◯	◯
malaise	◯	◯
sweats	◯	◯
night sweats	◯	◯
weight gain	◯	◯
weight loss	◯	◯

ENMT

◯ None	Y	N
difficulty swallowing	◯	◯
dizziness	◯	◯
ear pain	◯	◯
nasal obstruction	◯	◯
nose bleeds	◯	◯
sore throat	◯	◯
hearing loss	◯	◯

Endocrine

◯ None	Y	N
cold intolerance	◯	◯
excessive thirst	◯	◯
hair loss	◯	◯
heat intolerance	◯	◯

Eyes

◯ None	Y	N
blurred vision	◯	◯
double vision	◯	◯
dry eyes	◯	◯
loss of vision	◯	◯
eye pain with bright light	◯	◯
red eyes	◯	◯

Gastrointestinal

◯ None	Y	N
abdominal pain	◯	◯
abdominal swelling	◯	◯
change in bowel habits	◯	◯
constipation	◯	◯
dairy intolerance	◯	◯
diarrhea	◯	◯
difficulty swallowing	◯	◯
gas	◯	◯
heartburn	◯	◯
loss of bowel control	◯	◯
jaundice	◯	◯
nausea	◯	◯
stomach cramps	◯	◯
rectal bleeding	◯	◯
rectal Pain	◯	◯
vomiting	◯	◯

Genitourinary

◯ None	Y	N
dark urine	◯	◯
decrease in urine flow	◯	◯
dysuria	◯	◯
frequent urinary infections	◯	◯
frequent urination	◯	◯
blood in the urine	◯	◯
impotence	◯	◯
frequent night time urination	◯	◯
uretheral discharge	◯	◯
urinary leakage or accidents	◯	◯

Hematologic/Lymphatic

◯ None	Y	N
bleeding gums	◯	◯
easy bruising	◯	◯
swollen lymph nodes	◯	◯
prolonged bleeding	◯	◯

Integumentary

◯ None	Y	N
allergies	◯	◯
dryness	◯	◯
hives	◯	◯
itching	◯	◯
jaundice	◯	◯
lesions	◯	◯
rashes	◯	◯

Musculoskeletal

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

Neurological

◯ None	Y	N
dizziness	◯	◯
fainting	◯	◯
frequent headaches	◯	◯
migraine	◯	◯
numbness or tingling	◯	◯
recent fall	◯	◯
seizures	◯	◯
tremors	◯	◯
vertigo	◯	◯
memory loss	◯	◯

Psychiatric

◯ None	Y	N
anxiety	◯	◯
depression	◯	◯
difficulty sleeping	◯	◯
hallucinations	◯	◯
nervousness	◯	◯
panic attacks	◯	◯
paranoia	◯	◯

Respiratory

◯ None	Y	N
asthma	◯	◯
cough	◯	◯
dyspnea	◯	◯
excessive sputum	◯	◯
coughing up blood	◯	◯
shortness of breath with exercise	◯	◯
wheezing	◯	◯

Reviewed with

◯ Patient ◯ Parent ◯ Guardian ◯ Not Present

Signature

Signature Date