HAWAII GASTROENTEROLOGY SPECIALISTS

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Patient Interview Form

Patient Information

First Name:________________ Last Name:________________

Date Of Birth:________________ Age:________________

Contact Preference

- ◯ Email
- ◯ Cell phone
- ◯ Telephone call- Work
- ◯ Telephone call - Home
- ◯ Patient Portal
- ◯ Patient declines to specify
- Other:______________

Email

Please check one as your preferred email for communications

◯ Personal:________________ ◯ Work:________________

Preferred Language

- ◯ Chinese
- ◯ English
- ◯ Japanese
- ◯ Korean
- ◯ Samoan
- ◯ Spanish; Castilian
- ◯ Tagalog
- ◯ Tonga (Tonga Islands)
- ◯ Vietnamese
- ◯ Patient declines to specify

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

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

- ◯ Yes
- ◯ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

- ☐ Yes
- ☐ No

Social History

Occupation:____________________ Number of Children:____________________

Marital Status

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

Alcohol

- ☐ None

Type	Number	Frequency
☐ Rarely		Times / year
☐ Occasionally		Times / month
☐ Moderately		Times / week
☐ Daily		Times / day

Caffeine

- ☐ None
- ☐ Daily
- ☐ Occasionally

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	Number	Frequency
☐ Recreational		Times / month
☐ IV or intranasal drugs		Times / month

Exercise

- ☐ None

Type	Number	Frequency
☐ Occasional		Times / month
☐ Regular		Times / week

Immunizations

- None

- Flu vaccine — When:______________
- Pneumovax — When:______________
- Hep A — When:______________
- Hep B — When:______________
- Other:______________

Diagnostic Studies/Tests

- None

- EGD — When:______________
- Colonoscopy — When:______________
- Flexible Sigmoidoscopy — When:______________
- ERCP — When:______________
- EUS — When:______________
- Abdominal Ultrasound — When:______________
- CT Abdomen/Pelvis — When:______________
- MRI Abdomen/Pelvis — When:______________
- Mammogram — When:______________

Previous Procedures

- None

- Abdominal aortic aneurysm (AAA) repair — When:______________
- Appendectomy — When:______________
- Back Surgery — When:______________
- Bariatric Surgery — When:______________
- Bilateral Tubal Ligation (BTL) — When:______________
- Breast Surgery — When:______________
- Cardiac Cath - with stent placement — When:______________
- Cholecystectomy — When:______________
- Colon resection/ Colectomy — When:______________
- Coronary Artery Bypass Graft (CABG) — When:______________
- D & C — When:______________
- Defibrillator Placement — When:______________
- Exploratory Laparoscopy — When:______________
- Fundoplication - Nissen (Acid Reflux) — When:______________
- Heart valve replacement — When:______________
- Hemorrhoid banding — When:______________
- Hemorrhoidectomy — When:______________
- Hysterectomy — When:______________
- Joint Replacement — When:______________
- Pacemaker Insertion — When:______________
- PEG tube placement — When:______________
- Small Bowel Resection - Segmental — When:______________
- Whipple Procedure (Pancreatico-duodenectomy) — When:______________
- Other:______________

Past or Present Medical Conditions

☐ None

Cardiology

- ☐ Angina When: ______
- ☐ Anticoagulation Therapy When: ______
- ☐ Arrhythmia When: ______
- ☐ Atrial Fibrillation When: ______
- ☐ Brain Aneurysm When: ______
- ☐ Congestive Heart Failure When: ______
- ☐ Coronary Artery Stents When: ______
- ☐ Coronary Artery Disease When: ______
- ☐ Defibrillator When: ______
- ☐ Heart Attack When: ______
- ☐ Heart Murmurs When: ______
- ☐ Hyperlipidemia When: ______
- ☐ Hypertension When: ______
- ☐ Mitral Valve Prolapse/MR When: ______
- ☐ Myocardial infarction When: ______
- ☐ Pacemaker When: ______
- ☐ Palpitations When: ______
- ☐ Stroke When: ______
- ☐ Transient Ischemic Attack When: ______
- ☐ Vascular Disease When: ______
- Other: ______

Gastroenterology

- ☐ Barrett's Esophagus When: ______
- ☐ Celiac Disease When: ______
- ☐ Colon polyp When: ______
- ☐ Crohn's Disease When: ______
- ☐ Diverticulitis When: ______
- ☐ Diverticulosis When: ______
- ☐ Gastroesophageal Reflux Disease (GERD) When: ______
- ☐ Gastric Ulcer When: ______
- ☐ Gastritis When: ______
- ☐ H. Pylori Infection When: ______
- ☐ Hemorrhoids When: ______
- ☐ Irritable Bowel Syndrome When: ______
- ☐ Iron Deficiency Anemia When: ______
- ☐ Ulcer Disease When: ______
- ☐ Ulcerative Colitis When: ______
- Other: ______

Hepatology

- ☐ Cirrhosis When: ______
- ☐ Elevated Liver Function Test When: ______
- ☐ Fatty Liver When: ______
- ☐ Gallstones When: ______
- ☐ Hepatitis A When: ______
- ☐ Hepatitis B When: ______
- ☐ Hepatitis C When: ______
- ☐ Pancreatitis When: ______
- Other: ______

Pulmonology

- ☐ Asthma When: ______
- ☐ Blood Clots When: ______
- ☐ C.O.P.D. When: ______
- ☐ Emphysema When: ______
- ☐ Sleep apnea When: ______
- ☐ Wheezing When: ______
- Other: ______

Oncology

- ☐ Breast cancer When: ______
- ☐ Colon cancer When: ______
- ☐ Gastric Cancer When: ______
- ☐ Lung cancer When: ______
- ☐ Ovarian Cancer When: ______
- ☐ Prostate Cancer When: ______
- ☐ Skin Cancer When: ______
- Other: ______

Other

- ☐ Current pregnancy When: ______
- ☐ Anxiety disorder When: ______
- ☐ Arthritis When: ______
- ☐ Bipolar disorder When: ______
- ☐ Body piercings When: ______
- ☐ Cataracts When: ______
- ☐ Carpal Tunnel Syndrome When: ______
- ☐ Depression When: ______
- ☐ Diabetes Mellitus, Insulin Dependent (Type 1) When: ______
- ☐ Diabetes Mellitus, Non-Insulin Dependent (Type 2) When: ______
- ☐ Fibrositis / Fibromyalgia When: ______
- ☐ Gout When: ______
- ☐ Hematuria When: ______
- ☐ HIV infection When: ______
- ☐ Hypothyroidism When: ______
- ☐ Kidney disease When: ______
- ☐ Kidney stones When: ______
- ☐ Migraines When: ______
- ☐ Obesity When: ______
- ☐ Osteoporosis When: ______

- [ ] Psoriasis When:______________
- [ ] Renal Failure When:______________
- [ ] Seizures When:______________
- [ ] Tattoos When:______________

Other:______________

Family Medical History

- [ ] No knowledge of family history

No family history of

- [ ] Anesthesia reactions
- [ ] Celiac sprue
- [ ] Colon cancer
- [ ] Colon polyps
- [ ] Crohn's disease
- [ ] Liver disease
- [ ] Stomach cancer
- [ ] Ulcerative Colitis / IBD

Diagnoses	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Anesthesia reactions	○	○	○	○	○	○	○	○
Celiac disease	○	○	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○	○	○
Stomach cancer	○	○	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○

Allergies

- [ ] Patient has no known allergies
- [ ] Patient has no known drug allergies

- [ ] Adhesive Tape
- [ ] Codeine Sulfate
- [ ] Erythromycin
- [ ] Penicillins
- [ ] Propofol Analogues
- [ ] IV Dye, Iodine And Iodide Containing Products
- [ ] Latex
- [ ] Soy
- [ ] Eggs
- [ ] Shellfish

Other: ____________

Current Medications

- [ ] None

Name	Dose	How taken?

Pharmacy

Name	Address	Phone

Consent to Import Medication History

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

- [ ] Yes
- [ ] No

Reviewed with

- [ ] Patient
- [ ] Parent
- [ ] Guardian
- [ ] Not Present

Signature

Signature ____________ Date ____________

Review Of Systems

Allergic/Immunologic

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

Cardiovascular

None	Y	N
chest pain	○	○
dyspnea with exercise	○	○
irregular heart beat	○	○
orthopnea	○	○
palpitations	○	○
peripheral edema	○	○
syncope	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
malaise	○	○
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
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	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
difficulty swallowing	○	○

Genitourinary

None	Y	N
dark urine	○	○
decrease in urine flow	○	○
dysuria	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○
impotence	○	○
nocturia	○	○
urethral discharge or incontinence	○	○

Hematologic/Lymphatic

None	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
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	○	○
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	○	○