Kansas Gastroenterology, LLC
3121 N. Webb Road, Suite 101
Wichita, KS 67226-8119
Phone: (316) 261-3130
Fax: (316) 261-3275

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Today's Date:_____

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

☐ Other Race ☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law ☐ Unknown

Sex

☐ Male ☐ Female ☐ Other ☐ Unknown

Preferred Language

☐ English ☐ Spanish; Castilian ☐ Patient declines to specify

Contact Preference

☐ Letter ☐ Cell phone ☐ Portal ☐ Home Phone

Pharmacy

Name Address Phone

Allergies

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

☐ Adhesive Tape ☐ Codeine Sulfate ☐ Erythromycin ☐ Penicillins ☐ Shellfish

☐ Iv Dye, Iodine Containing ☐ Latex gloves

Other:_____

Current Medications

☐ None ☐ Uses oxygen

Name / Dose / Form / How taken (eg. Tylenol 500mg 1 tablet by mouth twice daily as needed)

_____

_____

_____

_____

_____

_____

Diagnostic Studies/Tests

☐ None

☐ Colonoscopy When:_____

☐ EGD When:_____

☐ CT Abdomen/Pelvis When:_____

☐ MRI Abdomen/Pelvis When:_____

☐ ERCP When:_____

☐ Gastric Emptying Study When:_____

☐ Hemoccult When:_____

☐ Cologuard When:_____

☐ Flexible Sigmoidoscopy When:_____

☐ Endoscopic Ultrasound When:_____

Previous Procedures

☐ None

☐ Gallbladder removed
☐ Appendectomy
☐ Colon resection
☐ Small Bowel Resection
☐ Exploratory Laparoscopy
☐ Gastric Bypass
☐ Gastric Lap Band
☐ Hemorrhoidectomy
☐ Hemorrhoid banding
☐ Abdominoplasty
☐ Hysterectomy - Abdominal
☐ Bilateral Tubal Ligation (BTL)
☐ Mastectomy L Breast
☐ Mastectomy R Breast
☐ Pacemaker Insertion
☐ Defibrillator Placement
☐ Coronary Artery Bypass Graft (CABG)
☐ Abdominal aortic aneurysm (AAA) repair
☐ Aortic Heart valve replacement
☐ Mirtral Heart valve replacement
☐ Cardiac Cath - with stent placement
☐ Joint Replacement
☐ Back Surgery
Other:_____
Other:_____

Past or Present Medical Conditions

☐ None

Gastroenterology/Hepatology

☐ Colon polyp history
☐ Colon cancer
☐ Irritable Bowel Syndrome
☐ Diverticulosis
☐ Crohn's Disease
☐ Ulcerative Colitis
☐ Gastroesophageal Reflux Disease (GERD)
☐ Barrett's Esophagus
☐ Ulcer Disease
☐ Hepatitis B
☐ Hepatitis C
☐ Fatty Liver
☐ Cirrhosis
☐ Celiac Disease
☐ Bowel Obstruction
☐ Pancreatitis
☐ Anemia
☐ Esophageal Cancer
Other:_____
Other:_____

Cardiology

☐ Coronary Artery Disease
☐ Congestive Heart Failure
☐ Myocardial Infarction (Heart Attack)
☐ High blood pressure
☐ Atrial Fibrillation
☐ Vascular Disease
☐ High Cholesterol
☐ Stroke
☐ Transient Ischemic Attack (Mini-stroke)
☐ Valvular heart disease
☐ Pacemaker
☐ Coronary Artery Stents
Other:_____
Other:_____

Pulmonology

☐ C.O.P.D.
☐ Asthma
☐ Sleep apnea
☐ Blood Clots (leg)
☐ Blood Clots (lung)
☐ Wheezing
Other:_____
Other:_____

Continues on next page

Other

- ⬭ Anxiety disorder
- ⬭ Arthritis
- ⬭ Bipolar disorder
- ⬭ Body piercings
- ⬭ Breast cancer
- ⬭ Current pregnancy
- ⬭ Depression
- ⬭ Diabetes Mellitus, Insulin Dependent (Type 1)
- ⬭ Diabetes Mellitus, Non-Insulin Dependent (Type 2)
- ⬭ Fibrositis / Fibromyalgia
- ⬭ Gout
- ⬭ HIV exposure
- ⬭ HIV infection
- ⬭ Hypothyroidism
- ⬭ Kidney disease
- ⬭ Kidney stones
- ⬭ Lung cancer
- ⬭ Ovarian Cancer
- ⬭ Prostate Cancer
- ⬭ Skin Cancer
- ⬭ Seizures
- ⬭ Tattoos

Social History

Occupation:_____Number of Children:_____

Marital Status

- ⬭ Single
- ⬭ Married
- ⬭ Divorced
- ⬭ Separated
- ⬭ Widowed
- ⬭ Civil Union
- ⬭ Unknown
- ⬭ Other

Alcohol

- ⬭ None
- ⬭ Occasionally
- ⬭ Daily
- ⬭ Former Drinker

Caffeine

- ⬭ None
- ⬭ Occasionally
- ⬭ Daily

Nicotine

Use Status

- ⬭ Current every day use
- ⬭ Current some day use
- ⬭ Former used
- ⬭ Never used

Type used	Started	Quit	Quantity	Frequency
⬭ Cigarettes				
⬭ Cigars				
⬭ Chewing Tobacco				
⬭ Vaping				

Drug Use

- ⬭ None

Type	Quantity	Number	Frequency
⬭ IV or intranasal drugs			Times / month
⬭ Recreational			Times / month

Exercise

- ⬭ None
- ⬭ Regular exercise
- ⬭ Occasional exercise

Family Medical History

No knowledge of family history

	Mother	Father	Sister	Brother	Grandmother	Grandfather	None
Diagnoses							
Celiac Disease	○	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○	○
Esophageal cancer	○	○	○	○	○	○	○

Review Of Systems: Check the circle of the symptoms below you are having today

Cardiovascular
- Chest pain
- Palpitations
- High blood pressure
- Shortness of breath while lying down or sleeping

Constitutional
- Fever
- Loss of appetite
- Weight loss
- Weakness
- Tire easily
- Light headedness

ENMT
- Nose bleeds
- Sore throat
- Hearing loss
- Ringing sensation
- Sinus trouble
- Hay fever
- Sore mouth
- Hoarseness

Endocrine
- Excessive thirst
- Heat intolerance
- Cold intolerance
- Excessive sweating
- Excessive hunger

Eyes
- Yellow eyes
- Contact lenses/glasses

Gastrointestinal
- Abdominal pain
- Abdominal swelling
- Constipation
- Diarrhea
- Nausea
- Vomiting
- Difficulty swallowing
- Milk intolerance
- Indigestion
- Vomiting blood
- Blood in stools
- Hard stools
- Use finger to evacuate stools

Psychiatric
- Difficulty sleeping
- Nervousness
- Tension
- Manic Symptoms
- Bad mood

Respiratory
- Asthma
- Cough
- Dyspnea (shortness of breath)
- Wheezing

Genitourinary
- Frequent urination
- Hematuria
- Impotence
- Urgent urination
- Difficulty holding urine/accidents
- Burning with urination
- Sores
- Pain during intercourse
- Loss of interest in sex
- Past sexually transmitted infection
- Difficulty with periods
- Excessive bleeding during periods
- Menopause

Hematologic/lymphatic
- Easy bruising
- Prolonged bleeding
- Blood transfusions before 1992
- Transfusion reaction
- Anemia
- Excessive blood loss

Integumentary (skin)
- Dryness
- Itching
- Lesions
- Rashes
- Tattoos
- Body piercing
- Leg ulcers
- Foot ulcers

Musculoskeletal
- Back pain
- Joint pain
- Muscle pain
- Leg cramps

Neurological
- Dizziness
- Fainting
- Frequent headaches
- Tremors
- Memory loss
- Blackouts
- Paralysis
- Numbness
- Confusion

- None of the above symptoms

Medical Providers (Please list below the physicians currently treating your conditions)

Primary Care Physician: _____

Cardiologist: _____

Endocrinologist: _____

Transplant Physician: _____

Oncologist: _____

Nephrologist: _____

Other (please specify the condition): _____

_____

_____

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