



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

Personal: _____ Work: _____

Race

Select one or more:

- | | | | | |
|--|---|-------------------------------|---|---|
| <input type="radio"/> White | <input type="radio"/> Black or African American | <input type="radio"/> Asian | <input type="radio"/> American Indian or Alaskan Native | <input type="radio"/> Native Hawaiian or Other Pacific Islander |
| <input type="radio"/> Middle Eastern or North African (MENA) | <input type="radio"/> Other Race | <input type="radio"/> Unknown | <input type="radio"/> Patient Declines to Specify | <input type="radio"/> Prohibited by State Law |

Ethnicity

- | | | | | |
|--|--|---|---|-------------------------------|
| <input type="radio"/> Hispanic or Latino | <input type="radio"/> Not Hispanic or Latino | <input type="radio"/> Patient Declines to Specify | <input type="radio"/> Prohibited by State Law | <input type="radio"/> Unknown |
|--|--|---|---|-------------------------------|

Sex

- | | | | |
|----------------------------|------------------------------|-----------------------------|-------------------------------|
| <input type="radio"/> Male | <input type="radio"/> Female | <input type="radio"/> Other | <input type="radio"/> Unknown |
|----------------------------|------------------------------|-----------------------------|-------------------------------|

Preferred Language

- | | | | |
|-------------------------------|--|-----------------------------|---|
| <input type="radio"/> English | <input type="radio"/> Spanish; Castilian | <input type="radio"/> Other | <input type="radio"/> Patient Declines to Specify |
|-------------------------------|--|-----------------------------|---|

Contact Preference

- | | | | |
|------------------------------|----------------------------------|--------------------------------------|----------------------------------|
| <input type="radio"/> Letter | <input type="radio"/> Cell Phone | <input type="radio"/> Patient Portal | <input type="radio"/> Home Phone |
|------------------------------|----------------------------------|--------------------------------------|----------------------------------|

Pharmacy

Name	Address	Phone Number
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Allergies

- | | | | | |
|--|---|------------------------------------|-----------------------------------|---------------------------------|
| <input type="radio"/> Patient has no known allergies | <input type="radio"/> Patient has no known drug allergies | | | |
| <input type="radio"/> Adhesive Tape | <input type="radio"/> Codeine | <input type="radio"/> Erythromycin | <input type="radio"/> Penicillins | <input type="radio"/> Shellfish |
| <input type="radio"/> Iv Dye, Iodine Containing | <input type="radio"/> Latex | Other: _____ | | |

Current Medications

None Uses Oxygen

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

Diagnostic Tests/Studies

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: _____

Endoscopy
Ultrasound

When: _____

Previous Procedures

None

Gallbladder Removal

Appendectomy

Colon Resection

Small Bowel Resection

Exploratory Laparoscopy

Gastric Bypass

Gastric Lap Band

Hemorrhoidectomy

Hemorrhoid Banding

Abdominoplasty

Hysterectomy

Bilateral Tubal Ligation (BTL)

Mastectomy L Breast

Mastectomy R Breast

Pacemaker Insertion

Defibrillator Placement

Coronary Artery Bypass Graft (CABG)

Abdominal Aortic Aneurysm Repair (AAA)

Aortic Heart Valve Replacement

Mitral 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: _____

Other

<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Body Piercings
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Current Pregnancy	<input type="checkbox"/> Depression	<input type="checkbox"/> Type 1 Diabetes Mellitus
<input type="checkbox"/> Type 2 Diabetes Mellitus	<input type="checkbox"/> Fibrositis/ Fibromyalgia	<input type="checkbox"/> Gout	<input type="checkbox"/> HIV Exposure
<input type="checkbox"/> HIV Infection	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Seizures	<input type="checkbox"/> Tattoos	<input type="checkbox"/> Dementia	<input type="checkbox"/> Alzheimer's

Other: _____ Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed
<input type="checkbox"/> Civil Union	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other		

Alcohol

<input type="checkbox"/> Never	<input type="checkbox"/> Daily	<input type="checkbox"/> Former Drinker
<input type="checkbox"/> Occasionally		

Caffeine

<input type="checkbox"/> Never	<input type="checkbox"/> Daily
<input type="checkbox"/> Occasionally	

Nicotine

Use Status	<input type="checkbox"/> Current Every Day Use	<input type="checkbox"/> Current Some Day Use	<input type="checkbox"/> Formerly Used	<input type="checkbox"/> Never Used
Type Used	Started	Quit	Quantity (e.g. 10 cigarettes)	Frequency (e.g. Daily)
<input type="checkbox"/> Cigarettes	_____			
<input type="checkbox"/> Cigars	_____			
<input type="checkbox"/> Chewing Tobacco	_____			
<input type="checkbox"/> Vaping	_____			

Drug Use

<input type="checkbox"/> Never			
Type	Quantity	Number	Frequency
<input type="checkbox"/> IV/Intranasal	_____		
<input type="checkbox"/> Recreational	_____		

Exercise

<input type="checkbox"/> Never	<input type="checkbox"/> Occasional Exercise
<input type="checkbox"/> Regular Exercise	

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 (Heart Doctor): _____

Endocrinologist: _____

Transplant Physician: _____

Oncologist: _____

Nephrologist: _____

Pulmonologist: _____

Other (please specify the condition): _____

Consent to Import Medication History

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

(This allows us to import medications your insurance has paid for at a pharmacy to our system without having to type each one manually)

Yes

No

Reviewed With

Patient

Parent

Guardian

Not Present

Signature

Signature

Date