GI PARTNERS
of ILLINOIS, LLC

Telephone-(847) 247-0187
Fax-(847)247-0487

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 ◯ Prohibited by state law

Ethnicity

◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Patient declines to specify

Sex

◯ Male ◯ Female ◯ Other

Preferred Language

◯ English ◯ Patient declines to specify

Contact Preference

◯ Patient Portal ◯ Patient declines to specify Other:_____

Allergies

◯ Patient has no known allergies ◯ Patient has no known drug allergies

◯ Aspirin ◯ Penicillins ◯ fentanyl ◯ Sulfa (Sulfonamide Antibiotics) ◯ Propofol

◯ Versed ◯ latex gloves Other:_____

Current Medications

○ None

Name	Dose	How taken?

Immunizations

- ◯ None
- ◯ Hep A When:_____
- ◯ Hep B When:_____
- ◯ Influenza vaccine When:_____
- ◯ Pneumonia Vaccine When:_____
- Other:_____

Diagnostic Studies/Tests

- ◯ None
- ◯ Colonoscopy When:_____
- ◯ Upper Endoscopy When:_____
- ◯ Abdominal U/S When:_____
- ◯ CT Abdomen w/o dye When:_____
- ◯ OTHER When:_____

Past or Present Medical Conditions

- ◯ None
- ◯ C.O.P.D. When:_____
- ◯ Asthma When:_____
- ◯ Diabetes Mellitus When:_____
- ◯ GERD When:_____
- ◯ Hepatitis B When:_____
- ◯ Hepatitis C When:_____
- ◯ IBS When:_____
- ◯ Liver Disease When:_____
- ◯ Pacemaker When:_____
- ◯ Sleep apnea When:_____
- ◯ HIV When:_____
- ◯ Hypertension When:_____
- ◯ Ischemic Heart Disease When:_____
- ◯ OTHER When:_____

Previous Procedures

- ◯ None
- ◯ Gallbladder removed When:_____
- ◯ Pacemaker Atrial & Ventricular When:_____
- ◯ Hysterectomy When:_____
- ◯ Hernia Repair When:_____
- ◯ Gastric By-Pass When:_____
- ◯ OTHER When:_____

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

Type	Started	Quit	Quantity	Frequency

Drug Use

⬭ None

Type	Quantity	Number	Frequency

Exercise

⬭ None

Type	Quantity	Number	Frequency

Family Medical History

⬭ No knowledge of family history

No family history of

- ⬭ Colitis, chronic Crohns
- ⬭ Colon cancer
- ⬭ Colon polyps

Diagnoses	Mother	Father	Sister	Brother	Son	Daughter
Family hx of esophageal cancer	○	○	○	○	○	○
Family hx of colon cancer	○	○	○	○	○	○
Family hx of colon polyps	○	○	○	○	○	○
Family hx ot cardiovascular disease	○	○	○	○	○	○
Family hx diabetes mellitus	○	○	○	○	○	○
Family History of crohn's	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

	Y	N
○ None		
HIV exposure	○	○
persistent infections	○	○

Cardiovascular

	Y	N
○ None		
chest pain	○	○
irregular heart beat	○	○
palpitations	○	○

Constitutional

	Y	N
○ None		
fatigue	○	○
fever	○	○
loss of appetite	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

ENMT

	Y	N
○ None		
difficulty swallowing	○	○
dizziness	○	○
nose bleeds	○	○
sore throat	○	○
sinus trouble	○	○
loss of voice	○	○

Endocrine

	Y	N
○ None		
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Eyes

	Y	N
○ None		
double vision	○	○
loss of vision	○	○
sensitivity to light	○	○

Gastrointestinal

	Y	N
○ None		
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
difficulty swallowing	○	○
black stool	○	○
abdomen filling up with fluid	○	○

Genitourinary

	Y	N
○ None		
dark urine	○	○
decrease in urine flow	○	○
painful urination	○	○
frequent urinary infections	○	○
frequent urination	○	○
blood in urine	○	○
impotence	○	○
need to urinate at night	○	○
urethral discharge or incontinence	○	○

Hematologic/Lymphatic

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

Integumentary

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

Musculoskeletal

	Y	N
○ None		
arthritis	○	○
back pain	○	○
gout	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

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

Psychiatric

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

Respiratory

	Y	N
○ None		
asthma	○	○
cough	○	○
shortness of breath	○	○
excessive sputum	○	○
coughing up blood	○	○
wheezing	○	○

Pharmacy

Name Address Phone

Consent to Import Medication History

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

○ Yes ○ No

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

Reviewed with

○ Patient ○ Parent ○ Guardian ○ Not Present