**GASTROENTEROLOGY CENTER OF NORTHERN VIRGINIA, LTD.**

Gabriel B. Herman, M.D.
Pradeep K. Gupta, M.D.
Truc T. Trinh, M.D.
Diego I. Kuperschmit, M.D.
Rachana Potru, M.D.

*Arlington:*
1715 NORTH GEORGE MASON DRIVE
SUITE 204
ARLINGTON, VA 22205
TEL. (703) 522-7476
FAX: (703) 528-4209

*Annandale:*
3289 WOODBURN RD.
SUITE 220
ANNANDALE, VA 22003
TEL: (703) 560-6106
FAX: (703) 204-1968

# Patient Interview Form

## Patient Information

First Name:______________________ Last Name:______________________

Date Of Birth:______________________

**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 ○ Prohibited by state law

**Sex**

○ Male ○ Female ○ Other

**Preferred Language**

○ English ○ Patient declines to specify

**Contact Preference**

○ Letter ○ Email ○ Patient declines to specify Other:____________

## 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: ____________ Other: ____________

## Current Medications

○ None

| Name | Dose | How taken? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Immunizations

○ None

○ Flu vaccine When: ____________

○ Hep A When: ____________

○ Hep B When: ____________

○ Pneumovax When: ____________

○ TB skin test When: ____________

## Diagnostic Studies/Tests

○ None

○ Colonoscopy When: ____________

○ EGD When: ____________

○ CT Abdomen/Pelvis When: ____________

○ MRI Abdomen/Pelvis When: ____________

○ ERCP 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 R Breast ○ Pacemaker Insertion ○ Defibrillator Placement

○ Coronary Artery Bypass Graft (CABG) ○ Abdominal aortic aneurysm (AAA) repair ○ Heart valve replacement ○ Cardiac Cath - with stent placement ○ Joint Replacement

○ Back Surgery ○ Fibromyalgia Other: ____________ Other: ____________

## Past or Present Medical Conditions

○ None

| | | | | |
|---|---|---|---|---|
| **Gastroenterology/Hepatology** | ○ Colon polyp history | ○ Colon cancer | ○ Irritable Bowel Syndrome | ○ Diverticulitis |
| | ○ 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 | Other: ______ | Other: ______ | |
| **Cardiology** | ○ Coronary Artery Disease | ○ Congestive Heart Failure | ○ Heart Attack | ○ High blood pressure |
| | ○ Atrial Fibrillation | ○ Vascular Disease | ○ High Cholesterol | ○ Stroke |
| | ○ Transient Ischemic Attack | ○ 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** | ○ 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

Type

○ Occasionally

○ Daily

Quantity ______

______

**Caffeine**

○ None

○ Occasionally ○ Daily

**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 |
|---|---|---|---|---|
| ○ Cigarettes | | | | |
| ○ Cigar | | | | |
| ○ Chewing Tobacco | | | | |

**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

**No family history of**

○ Celiac sprue
○ Colon polyps
○ Liver disease
○ Ulcerative Colitis / IBD
○ Colon cancer
○ Crohn's disease
○ Stomach cancer

| **Health Status** | Mother | Father | Sister | Brother | Grandmother | Grandfather |
|---|---|---|---|---|---|---|
| Age/Date of Birth | | | | | | |
| Healthy | ○ | ○ | ○ | ○ | ○ | ○ |
| Ill | ○ | ○ | ○ | ○ | ○ | ○ |
| Seriously Ill | ○ | ○ | ○ | ○ | ○ | ○ |
| Disabled | ○ | ○ | ○ | ○ | ○ | ○ |
| In Remission | ○ | ○ | ○ | ○ | ○ | ○ |
| Alive | ○ | ○ | ○ | ○ | ○ | ○ |
| Deceased/At Age | ○ ____ | ○ ____ | ○ ____ | ○ ____ | ○ ____ | ○ ____ |
| Cause of Death | | | | | | |
| **Diagnoses** | | | | | | |
| Celiac Disease | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon cancer | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon polyps | ○ | ○ | ○ | ○ | ○ | ○ |
| Crohn's disease | ○ | ○ | ○ | ○ | ○ | ○ |
| Gallbladder disease | ○ | ○ | ○ | ○ | ○ | ○ |
| Liver disease | ○ | ○ | ○ | ○ | ○ | ○ |
| Ulcerative colitis | ○ | ○ | ○ | ○ | ○ | ○ |
| Other: | ○ | ○ | ○ | ○ | ○ | ○ |

## 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 | ○ | ○ |

## Consent to Import Medication History

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

○ 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

## Signature

Signature Date

# Gastroenterology Center of Northern Virginia

Patient Name: ______________________________ Birthdate: __________

Who is your Primary Care Physician? ______________________________

What health insurance company is your coverage with? ____________________

Do you have an Advanced Directive? **Yes or No**

**An Advance Directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor.**

Have you had a pneumococcal (pneumonia) vaccine? **Yes or No**

Signature: ______________________________ Date: ______________