Central Texas
Gastroenterology Consultants

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# Patient Interview Form

## Patient Information

First Name:_____ Last Name:_____

MRN:_____ Date Of Birth:_____

Age:_____ Notes:_____

**Email**

Personal:_____

**Contact Preference**

☐ Email ☐ Cell phone ☐ Telephone call-Work ☐ Telephone call - Home ☐ Patient Portal

☐ Patient declines to specify

## Allergies

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

| | | | | |
|---|---|---|---|---|
| **General Allergies** | ☐ Dairy Products | ☐ Latex | ☐ Peanuts | ☐ Shellfish |
| | Other: | Other: | Other: | Other: |
| **Medication Allergies** | ☐ Penicillins | ☐ Sulfa | ☐ Codeine | ☐ Iodine |
| | ☐ Demerol | ☐ Aspirin | ☐ Fentanyl | ☐ Versed |
| | Other: | Other: | Other: | 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

## Review Of Systems

**Constitutional**

| None | Y | N |
|---|---|---|
| fever | | |
| loss of appetite | | |
| weight loss | | |

**Gastrointestinal**

| None | Y | N |
|---|---|---|
| abdominal pain | | |
| change in bowel habits | | |
| constipation | | |
| diarrhea | | |
| heartburn | | |
| nausea | | |
| rectal bleeding | | |
| vomiting | | |

## 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