Gastroenterology Specialists of Southwest Florida, P.A.
1656 Medical Blvd, Ste. 301 Naples, FL 34110
Ph. 239-593-6201 • Fax 239-593-6202
www.gastronaples.com

Diplomate, American Board of Gastroenterology

Steven Meckstroth, M.D. • Karina Sejas Hooper, PA-C • William Gonzalez, PA-C

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

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

Contact Preference

☐ email ☐ Phone Call ☐ All of the above ☐ Patient declines to specify

Allergies

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

☐ Codeine ☐ Penicillins ☐ Anesthesia ☐ Sulfa ☐ aspirin

Other:_____

Current Medications

☐ None

Name Dose

Immunizations

☐ None

☐ Hep A, adult ☐ Hep B, adult ☐ Influenza, seasonal, injectable ☐ Pneumonia

Past or Present Medical Conditions

☐ None

☐ Anemia ☐ Cirrhosis ☐ Colitis ☐ Colon cancer ☐ Colon polyps

☐ Crohn's Disease ☐ Pancreatitis ☐ Diabetes Mellitus ☐ Diverticulitis ☐ Diverticulosis

☐ Duodenal Ulcer ☐ Fatty Liver ☐ Gallstones ☐ Hepatitis ☐ Hepatitis B

☐ Hepatitis C ☐ Hiatal hernia ☐ IBS ☐ Lactose Intolerance ☐ Glaucoma

☐ Stomach Ulcer ☐ Ulcerative Colitis ☐ Asthma/COPD ☐ Atrial Fibrilation ☐ Back Pain (chronic)

☐ Breast cancer ☐ Skin Cancer ☐ Congestive Heart Failure ☐ Depression ☐ Stroke/Tia

☐ Heart Attack ☐ Heart Murmurs ☐ High blood pressure ☐ High Cholesterol ☐ High Triglycerides

☐ Irregular Heart Beat ☐ Chronic Kidney Disease ☐ TB exposure ☐ Migraines ☐ Osteoarthritis

☐ Seizures ☐ Sleep apnea ☐ Thyroid disorder ☐ Uterine Cancer ☐ Prostate Cancer

☐ HIV ☐ Ischemic heart disease ☐ Other _____ ☐ Coronary Artery Disease ☐ kidney stones

Previous Procedures

☐ None

☐ Colonoscopy ☐ EGD ☐ C-Section ☐ Cardiac Surgery ☐ Joint Surgery

☐ Gallbladder removed ☐ Thyroidectomy ☐ Tonsillectomy ☐ Pacemaker ☐ Nephrectomy

☐ Gastric By-Pass ☐ Gastric Band ☐ Breast Augmenation ☐ Hemorrhoidectomy ☐ Coronary artery bypass surgery

☐ Hysterectomy ☐ Prostatectomy ☐ Appendectomy ☐ Adenoidectomy ☐ Cardiac Cath.

Social History

Occupation:_____ Number of Children:_____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Alcohol

☐ None

Type Quantity Number Frequency

Drug Use

- ◯ None
- ◯ OTHER_____

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

Exercise

- ◯ None
- ◯ I walk
- ◯ I jog
- ◯ I Bike
- ◯ I Golf
- ◯ Tennis
- ◯ Lift Weights
- ◯ Swim
- ◯ Aerobics
- ◯ Yoga
- ◯ OTHER

Family Medical History

- ◯ No knowledge of family history

No family history of

- ◯ Colon cancer
- ◯ Polyps

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather
Colon Cancer - Age diagnosed____	○	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○	○
Ulcerative colitis, unspecified	○	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○	○
Family History of Diabetes	○	○	○	○	○	○	○	○
Impaired gallbladder function	○	○	○	○	○	○	○	○
Family History of Heart Trouble	○	○	○	○	○	○	○	○
Liver Disease/Cancer	○	○	○	○	○	○	○	○
Ulcer Disease	○	○	○	○	○	○	○	○
Irritable bowel syndrome	○	○	○	○	○	○	○	○
prostate cancer	○	○	○	○	○	○	○	○
breast cancer	○	○	○	○	○	○	○	○
Pancreas Cancer	○	○	○	○	○	○	○	○
Cervical/Uterine Cancer	○	○	○	○	○	○	○	○
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	○	○

Genitourinary

None	Y	N
dark urine	○	○
decrease in urine flow	○	○
dysuria	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○
impotence	○	○
nocturia	○	○
urethral discharge or incontinence	○	○

Gastrointestinal

None	Y	N
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
difficulty swallowing	○	○
dyspepsia	○	○
abdominal pain upper	○	○
abdominal pain lower	○	○
anal/rectal pain	○	○
belching	○	○
black stools	○	○
bloating	○	○
dairy intolerance	○	○
hemorrhoids	○	○
mucus in stool	○	○
pain with bowel movement	○	○
rectal urgency	○	○
reflux	○	○
soiling stool/incontinence	○	○
weight loss less than 10 lbs	○	○
weight loss more than 10 lbs	○	○
weight gain more than 10 lbs	○	○
weight gain less than 10 lbs	○	○

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

Pharmacy

Name Address Phone

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

◯ Yes ◯ No

Reviewed with

◯ Patient ◯ Parent ◯ Guardian ◯ Not Present