GI Excellence, Inc.

Gastroenterology Associates

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General Gastroenterology

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Advanced & Interventional Gastroenterology

Sandra Del Valle, PA-C
Gastroenterology Physician Assistant

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Gastroenterology Physician Assistant

Office Fax: (951) 658-6476 · Office Hours: 9 a.m. to 5 p.m, M - F

Two Locations:

HEMET
1003 E. Florida Avenue · Suite 101 · Hemet, CA 92543 · (951) 652-2252

TEMECULA
31515 Rancho Pueblo Rd. · Suite 202 · Temecula, CA 92592 · (951) 383-6001
(By appt.)

GI Excellence, Inc. 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: _____

Contact Preference:

☐ Letter ☐ Email ☐ Patient Declines to Specify ☐ Other: _____

Gender

☐ Male ☐ Female

Race

☐ White/Caucasian ☐ Black or African American ☐ Asian ☐ Hispanic or Latino ☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander ☐ Mixed ☐ Other ☐ Unknown ☐ Patient declines to provide information

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to provide information

Preferred Language

☐ English ☐ Spanish Other: _____

Allergies

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

☐ Aspirin, NSAIDs ☐ Codeine ☐ Penicillins ☐ Iodine ☐ Sulfa (Sulfonamide Antibiotics)

☐ Latex ☐ Versed ☐ Fentanyl ☐ Propofol Other: _____

Current Medications

☐ None

Name	Dose	How taken?

Immunizations

☐ None

☐ Hep B When : _____ ☐ Flu vaccine When : _____ ☐ DTaP When : _____ ☐ Pneumovax When : _____ ☐ Whooping When : _____

Diagnostic Studies/Tests

☐ None

☐ Endoscopy When: _____
☐ Colonoscopy When: _____
☐ CT Abdomen When: _____
☐ CT Pelvis When: _____
☐ Abdominal U/S When: _____
☐ Endoscopic Ultrasound When: _____
☐ Abdominal MRI/MRCP When: _____
☐ Other: When: _____

Past or Present Medical Conditions

☐ None

☐ Anemia When: _____
☐ Atrial Fibrilation When: _____
☐ Diabetes Mellitus When: _____
☐ Diverticulitis When: _____
☐ Coronary Artery Disease When: _____
☐ Barrets Esophagus When: _____
☐ Bleeding Ulcer When: _____
☐ Crohn's Disease When: _____
☐ Cirrhosis When: _____
☐ Colitis When: _____
☐ Colon cancer When: _____
☐ Colon polyps When: _____
☐ CVA When: _____
☐ Congestive Heart Failure When: _____
☐ Deep vein thrombosis When: _____
☐ Gallstones When: _____
☐ Gastritis When: _____
☐ GERD When: _____
☐ H. Pyloric When: _____
☐ Hemorrhoids When: _____
☐ Hepatitis When: _____
☐ Hepatitis B When: _____
☐ Hepatitis C When: _____
☐ Hiatal hernia When: _____
☐ High blood pressure When: _____
☐ IBS When: _____
☐ Iron Defficiency When: _____
☐ Myocardial infarction When: _____
☐ Peptic ulcer disease When: _____
☐ Pulmonary embolus When: _____
☐ S/p Gastric Bypass When: _____
☐ S/P GI bleed When: _____
☐ S/P Stents x3 When: _____
☐ TIA When: _____
☐ Other When: _____

Previous Procedures

☐ None:

☐ Aortic Valve Replacement When: _____
☐ Appendectomy When: _____
☐ Bladder Surgery When: _____
☐ Bypass Surgery When: _____
☐ C-Section When: _____
☐ Coronary Stents When: _____
☐ Colon Polyp removed When: _____
☐ Colon Resection When: _____
☐ Gallbladder removed When: _____
☐ Gastric Band When: _____
☐ Gastric By-Pass When: _____
☐ Hemicolectomy When: _____
☐ Hemorrhoidectomy When: _____
☐ Hysterectomy When: _____
☐ Inguinal Herniorraphy When: _____
☐ Liver biopsy When: _____
☐ Pacemaker When: _____
☐ Other When: _____

Social History

Occupation:_____ Number of Children:_____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
☐ Civil Union

Alcohol

☐ None

	Type	Quantity	Frequency
☐	wine	glasses	Times / week
☐	beer	cans/bottles	Times / week
☐	liquor	shots	Times / week

Tobacco Smoking Status

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker
☐ Smoker, current status unknown ☐ Unknown if ever smoked

Drug Use

☐ None

☐ Type _____ Quantity _____ Frequency _____

Family Medical History

☐ No knowledge of family history

No family history of ☐ Celiac disease ☐ Colon Cancer
☐ Colon Polyps ☐ Diverticulitis of colon

Pharmacy

Name:_____ Phone No._____

Consent to Import Medication History

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

☐ Yes ☐ No