DIGESTIVE HEALTH *Specialists*

Patient Interview Form

Patient Information

First Name: _____ Last Name: _____
Date of Birth: _____ Age:_____

Email
Personal: _____

Referring Physician
_____

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

Ethnicity

- ⬭ Hispanic or
- ⬭ Not Hispanic or Latino
- ⬭ Patient declines to specify

Nationality

- ⬭ United States of America
- ⬭ Mexico
- ⬭ Canada
- ⬭ Other:_____

Sex

- ⬭ Male
- ⬭ Female
- ⬭ Other

Preferred Language

- ⬭ English
- ⬭ Spanish; Castilian
- ⬭ Patient declines to specify

Other:_____

Contact Preference

- ⬭ Email
- ⬭ Phone
- ⬭ Letter
- ⬭ All preferences listed are acceptable
- ⬭ Patient declines to specify

Pharmacy

_____

Name Address Phone

Consent to Import Medication History

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

- ⬭ Yes
- ⬭ No

Allergies

- ⬭ Patient has no known allergies
- ⬭ Patient has no known drug allergies
- ⬭ Adhesive Tape
- ⬭ Penicillin
- ⬭ Eggs
- ⬭ Iodine
- ⬭ Latex
- ⬭ Sulfa

Other: _____

Current Medications

☐ None

Name Dose How taken?

_____

_____

_____

_____

_____

_____

_____

_____

Diagnostic Studies/Test

☐ None

☐ Colonoscopy When: _____

☐ EGD (upper endoscopy) When: _____

☐ Flexible Sigmoidoscopy When: _____

☐ ERCP (Endoscopic exam of the bile ducts) When: _____

☐ CT Scan Abdomen/Pelvis When: _____

☐ Abdominal ultrasound When: _____

☐ MRI of Abdomen/Pelvis When: _____

☐ Other When: _____

Previous Procedures

☐ None

☐ Hernia Repair

☐ Appendectomy

☐ C-Section

☐ Colon resection

☐ Coronary artery bypass grafting

☐ Coronary artery stent

☐ Gallbladder removed

☐ Heart valve replacement/surgery

☐ Hysterectomy

☐ Small bowel resection

☐ Lung surgery

☐ Weight loss surgery

☐ Tonsillectomy

Past or Present Medical Conditions

☐ None

☐ Anemia

☐ Anticoagulation therapy

☐ Asthma

☐ Atrial fibrillation

☐ Barrett's Esophagus

☐ Bleeding disorder

☐ Breast cancer

☐ Celiac disease

☐ Chronic kidney disease

☐ Cirrhosis

☐ Personal history of colon cancer

☐ Personal history of colon polyps

☐ Congestive heart failure

☐ COPD

☐ Coronary artery disease

☐ Crohn's disease

☐ Depression

☐ Diabetes

☐ Diverticulitis

☐ Diverticulosis

☐ Reflux-GERD

☐ H. pylori infection

☐ Hepatitis C

☐ Hepatitis B

☐ HIV/AIDS

☐ Home oxygen use

☐ Hypertension

☐ IBS

☐ Sleep apnea

☐ Stroke/TIA

☐ Pacemaker/Defibrillator

☐ Ulcerative colitis

☐ Seizure disorder

☐ Cancer Type: _____

☐ Thyroid disease Other: _____

☐ Pancreatitis Other: _____

☐ Osteoporosis

Other: _____

Social History

Occupation: _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Other

Alcohol

☐ None

Type	Quantity	Number	Frequency
☐ Beer			
☐ Wine			
☐ Hard Liquor			
☐ Recovering Alcoholic			

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

Drug Use

☐ None

☐ Current recreational drug use ☐ Current use of marijuana ☐ History of IV drug use ☐ Former recreational drug use

Family Medical History

☐ No knowledge of family history

No family history of

☐ Celiac sprue ☐ Colon Cancer

☐ Colon Polyps ☐ Liver Disease

☐ Ulcerative Colitis/IBD

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather
Family history of colonic polyps	○	○	○	○	○	○
Family history of malignant neoplasm of gastrointestinal tract	○	○	○	○	○	○
Crohn's disease / Ulcerative colitis	○	○	○	○	○	○
Disease of liver	○	○	○	○	○	○
Dysfunction of gallbladder	○	○	○	○	○	○
Celiac disease	○	○	○	○	○	○

Review of Systems

Cardiovascular	Y	N
chest pain	◯	◯
irregular heartbeat	◯	◯
swelling in legs/feet	◯	◯

Constitutional	Y	N
fatigue	◯	◯
fever	◯	◯
weight gain	◯	◯
weight loss	◯	◯

ENMT	Y	N
difficulty swallowing	◯	◯
sore throat	◯	◯
hoarseness	◯	◯

Endocrine	Y	N
excessive thirst	◯	◯
heat intolerance	◯	◯

Eyes	Y	N
loss of vision	◯	◯
blurred vision	◯	◯

Gastrointestinal	Y	N
abdominal pain	◯	◯
constipation	◯	◯
diarrhea	◯	◯
gas	◯	◯
heartburn	◯	◯
nausea	◯	◯
rectal bleeding	◯	◯
vomiting	◯	◯
black stools	◯	◯
bloating	◯	◯
blood in stool	◯	◯
leakage of stool	◯	◯
milk/dairy intolerance	◯	◯
mucus in stool	◯	◯

Genitourinary	Y	N
dark urine	◯	◯
frequent urination	◯	◯
painful urination	◯	◯
blood in urine	◯	◯
kidney stones	◯	◯

Hematologic/Lymphatic	Y	N
easy bruising	◯	◯
palpable lymph nodes	◯	◯

Integumentary	Y	N
rashes	◯	◯
jaundice (yellow skin)	◯	◯

Musculoskeletal	Y	N
back pain	◯	◯
joint pain	◯	◯
muscle weakness	◯	◯
stiffness	◯	◯

Neurological	Y	N
dizziness	◯	◯
frequent headaches	◯	◯
numbness or tingling	◯	◯
seizures	◯	◯

Psychiatric	Y	N
anxiety	◯	◯
depression	◯	◯

Respiratory	Y	N
cough	◯	◯
wheezing	◯	◯
shortness of breath	◯	◯
difficulty breathing	◯	◯
coughing up blood	◯	◯
excessive phlegm	◯	◯

Reviewed with

◯ Patient ◯ Parent ◯ Guardian ◯ Not Present

Signature

Patient Signature Date