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

- ☐ Home Phone
- ☐ Mobile Phone
- ☐ Work Phone
- ☐ 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

Abdominal 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

Pancreatitis

Osteoporosis

Other: _____

Other: _____

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

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

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