Digestive Health Specialists, PA

Patient Interview Form

Name:_________________________ **Date of Birth:**_______________ **Date:**_______________

Please complete all 3 pages. Mark any conditions you may have now, or have experienced in the past.

****Please mark "NONE" within each section that does not apply to you.****

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

Gender

- ◯ Male
- ◯ Female
- ◯ Other

Preferred Language

- ◯ English
- ◯ French
- ◯ Spanish
- ◯ Other:_______________

Allergies

- ◯ **Patient has no known allergies**
- ◯ **Patient has no known drug allergies**
- ◯ Aspirin
- ◯ Codeine
- ◯ Demerol
- ◯ Eggs
- ◯ Latex
- ◯ Morphine
- ◯ Penicillin
- ◯ Shellfish
- ◯ Sulfa
- ◯ Valium
- ◯ Versed
- ◯ Other:_______________

Past or Present Medical Conditions

- ◯ **NONE**
- ◯ Breast Cancer
- ◯ Colon Cancer
- ◯ Liver Cancer
- ◯ Lung Cancer
- ◯ Prostate Cancer
- ◯ Anemia
- ◯ Anxiety
- ◯ Arthritis
- ◯ Asthma
- ◯ Atrial Fibrillation
- ◯ Bipolar
- ◯ Blood Transfusions
- ◯ Chronic Lung Disease
- ◯ Colon Polyps
- ◯ Coronary Artery Disease
- ◯ Crohn's Disease
- ◯ Defibrillator
- ◯ Depression
- ◯ Diabetes
- ◯ Diverticulosis/Diverticulitis
- ◯ Emphysema/COPD
- ◯ Fibromyalgia
- ◯ Gallstones
- ◯ Heart Attack
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ Other Hepatitis
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ Home Oxygen
- ◯ Irritable Bowel Syndrome
- ◯ Kidney Disease
- ◯ Liver Disease
- ◯ Pancreatitis
- ◯ Pacemaker
- ◯ Malignant Hyperthermia
- ◯ Reflux
- ◯ Sleep Apnea
- ◯ Stroke
- ◯ Thyroid disorder
- ◯ Ulcer
- ◯ Ulcerative Colitis
- ◯ Other Colitis
- ◯ Other:_______________

Diagnostic Studies/Tests

- ◯ **NONE**
- ◯ Colonoscopy — When:__________
- ◯ Endoscopy — When:__________
- ◯ ERCP — When:__________
- ◯ Liver Biopsy — When:__________

Previous Procedures

- ◯ **NONE**
- ◯ Appendectomy
- ◯ Cardiac Cath
- ◯ Cardiac Stents
- ◯ Cardiac Surgery
- ◯ Colon Resection
- ◯ C-Section
- ◯ Gallbladder Surgery
- ◯ Heart Valve
- ◯ Hiatal Hernia Repair
- ◯ Hysterectomy
- ◯ Joint Replacement
- ◯ Mastectomy
- ◯ Obesity Surgery
- ◯ Prostate
- ◯ Other:_______________

Name:______________________________ **Date of Birth:**__________________

Occupation:________________________ **Hobbies:**________________________

Social History

Marital Status

◯ Single ◯ Married ◯ Divorced ◯ Seperated ◯ Widowed

Alcohol

◯ **NONE**

◯ Rarely ◯ Daily ◯ More than 2 days per weeks ◯ 2 days per week or less ◯ I quit using alcohol

Tobacco

Smoking Status

◯ Current every day smoker

◯ Current some day smoker

◯ Smoker, current status unknown

◯ Former Smoker

◯ Unknown if ever smoked

◯ Never smoker

Drug Use

◯ None

◯ I have used street drugs in the past ◯ I am currently using street drugs ◯ I have been treated for substance abuse

Review of Systems

Gastrointestinal

◯ **NONE**	Yes	No
blood in stool	◯	◯
trouble swallowing	◯	◯
constipation	◯	◯
other:		

Endocrine

◯ **NONE**	Yes	No
thyroid disorder	◯	◯
other:		

ENMT

◯ **NONE**	Yes	No
mouth sores	◯	◯
nose bleeds	◯	◯
other:		

Genitourinary

◯ **NONE**	Yes	No
frequent urinary infection	◯	◯
blood in urine	◯	◯
heavy periods	◯	◯
other:		

Constitutional

◯ **NONE**	Yes	No
fever	◯	◯
weight loss	◯	◯
weight gain	◯	◯
other:		

Cardiovascular

◯ **NONE**	Yes	No
angina/chest pain with activity	◯	◯
irregular heart beat/palpitations	◯	◯
swelling in legs	◯	◯
other:		

Integumentary

◯ **NONE**	Yes	No
jaundice	◯	◯
rash	◯	◯
other:		

Hematologic/ Lymphatic

◯ **NONE**	Yes	No
bleeding doesn't stop easily	◯	◯
frequent bruising	◯	◯
other:		

Neurological

◯ **NONE**	Yes	No
seizures	◯	◯
stroke/paralysis	◯	◯
other:		

Respiratory

◯ **NONE**	Yes	No
shortness of breath	◯	◯
chronic cough	◯	◯
TB	◯	◯
positive TB test	◯	◯
Use home 02	◯	◯
Use CPAP	◯	◯
other:		

Name:______________________________ **Date of Birth:**____________________

Family Medical History

◯ No knowledge of family history

No family history of: ◯ Colon Cancer ◯ Polyps

Health Status	Father	Mother	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Healthy	◯	◯	◯	◯	◯	◯	◯	◯
Alive	◯	◯	◯	◯	◯	◯	◯	◯
Deceased /	◯	◯	◯	◯	◯	◯	◯	◯
At age	________	________	________	________	________	________	________	________
Cause of Death	________	________	________	________	________	________	________	________
Diagnoses								
Alcoholism	◯	◯	◯	◯	◯	◯	◯	◯
Colitis (colon inflammation)	◯	◯	◯	◯	◯	◯	◯	◯
Colon cancer	◯	◯	◯	◯	◯	◯	◯	◯
Colon polyps	◯	◯	◯	◯	◯	◯	◯	◯
Liver disease	◯	◯	◯	◯	◯	◯	◯	◯
Ulcer disease	◯	◯	◯	◯	◯	◯	◯	◯
Other (write in)	________	________	________	________	________	________	________	________

Current Medications

(Please list all prescription and over the counter medications you are currently taking.)

◯ **NONE**

Name	Dose	Directions	Name	Dose	Directions

Pharmacy

Name:____

Reviewed with

◯ Patient ◯ Parent ◯ Guardian ◯ Not Present