Digestive Health Specialists, PA
Patient Interview Form

Name_____ **Date of Birth** ___/___/_____

Review of Systems

Gastrointestinal

◯ **NONE**	Yes	No
abdominal pain	◯	◯
rectal bleeding	◯	◯
diarrhea	◯	◯
trouble swallowing	◯	◯
constipation	◯	◯
other:		

Genitourinary

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

Integumentary

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

Blood Products

Can you accept Blood or Blood Products?	Yes	No
	◯	◯

Endocrine

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

Constitutional

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

Hematologic/ Lymphatic

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

ENMT

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

Cardiovascular

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

Current Medications

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

◯ **NONE**

Name	Dose	Directions	Name	Dose	Directions

Pharmacy

Name:_____
address phone#

Reviewed with

◯Patient ◯Parent ◯Guardian ◯Not Present