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.****

Allergies & Reactions

- ◯ **Patient has no known allergies**
- ◯ **Patient has no known drug allergies**
- ◯ Aspirin___________ ◯ Codeine___________ ◯ Demerol__________ ◯ Eggs__________ ◯ Latex__________
- ◯ Morphine_________ ◯ Penicillin__________ ◯ Shellfish__________ ◯ Sulfa__________ ◯ Valium_________
- ◯ Versed__________ ◯ Other:____________________

Blood Products

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

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	◯ Glaucoma	◯ HIV/AIDS
◯ Mobility issues	◯ Metal in body	◯ Airway issues during past procedure(s)	◯ Congestive Heart Failure/CHF	◯ 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:____________________________

Social History

Marital Status

◯Single ◯ Married ◯ Divorced ◯Separated ◯ Widowed

Alcohol

◯ **NONE**

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

Caffeine Type: Amount: Frequency:

Tobacco *(smoking or smokeless)*

◯ Current daily smoker ◯ Light or occasional smoker ◯Former smoker

◯ Never used tobacco ◯ Chewing or smokeless ◯Heavy 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

Exercise

◯None | ◯Exercises - Type of exercise(s): How often?

Name:____ **Date of Birth:**_______________________

Occupation:______________________________ **Hobbies:**_______________________________

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:		

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:		

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:		

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