Center for Digestive Health and Endoscopy Center

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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____

Email
Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Race
Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Other Race ☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law ☐ Unknown

Sex

☐ Male ☐ Female ☐ Other

Preferred Language

☐ Croatian ☐ English ☐ Spanish; Castilian ☐ Patient declines to specify

Contact Preference

☐ Call-Cell phone ☐ Call-Home *phone* ☐ Email ☐ Patient declines *to specify* Other:_____

Allergies

PLEASE WRITE REACTION i.e, rash, swelling, etc

☐ Patient has no known allergies ☐ Patient has no known drug allergies

☐ Aspirin-Like Analgesic, Salicylates ☐ Codeine Sulfate ☐ Demerol ☐ Eggs ☐ Iodine Containing Drugs

☐ Latex ☐ Penicillins ☐ Propofol ☐ Sulfa (Sulfonamides) ☐ Versed

☐ Ace Inhibitors ☐ Erythromycin ☐ IV Contrast ☐ Fentanyl ☐ Shellfish

Other:_____

Current Medications

○ None

Name Dose Instructions for taking: Once daily or one twice a day, etc

_____

_____

_____

_____

Immunizations

○ None

○ Pneumonia

When:_____

Past or Present Medical Conditions

○ None

○ Abnormal Liver Blood Tests ○ Anemia ○ Angina ○ Anxiety Disorder ○ Arthritis

○ Asthma ○ Atrial Fibrillation ○ Barrett's Esophagus ○ Bleeding Disorder ○ Blood Clots (DVT)

○ Breast Cancer ○ Celiac Sprue ○ Cirrhosis ○ Colon Cancer ○ Colon Polyps

○ Congestive Heart Failure ○ Coronary Artery Disease ○ Crohn's Disease ○ Depression ○ Diabetes Insulin Dependent - Type I

○ Diabetes Non Insulin Dependent - Type II ○ Diverticulosis ○ Emphysema ○ Endometriosis ○ Esophageal Cancer

○ Fibromyalgia ○ Gallstones ○ Gastroesophageal Reflux Disease ○ Gastrointestinal Bleeding ○ Gynecological Cancer

○ Heart Attack ○ Hemorrhoids ○ Hepatitis C ○ High Blood Pressure ○ High Cholesterol

○ Irritable Bowel Syndrome ○ Kidney Dialysis ○ Kidney Disease ○ Liver Disease ○ Lung Cancer

○ Lymphoma ○ Obesity ○ Ovarian Cancer ○ Pancreatitis ○ Prostate Cancer

○ Prostate Enlargement ○ Pulmonary Embolism ○ Seizure Disorder ○ Sleep Apnea ○ Stroke

○ Thyroid Disorder ○ Ulcer Disease ○ Ulcerative Colitis Other:_____

Previous Procedures Please include approximate date

○ None

○ AICD When:_____

○ Appendectomy/Appendix Removal When:_____

○ Back Surgery When:_____

○ Bladder Lift When:_____

○ C-Section When:_____

○ Cholecystectomy/Gallbladder Surgery When:_____

○ Colon Resection Partial When:_____

○ Coronary Artery Stent Placement When:_____

○ Gastric Bypass Surgery When:_____

○ Heart Bypass Operation When:_____

○ Heart Valve Replacement When:_____

○ Hemorrhoid Surgery When:_____

○ Hernia Repair When:_____

○ Joint Replacement When:_____

○ Mastectomy When:_____

○ Pacemaker When:_____

○ Prostate Surgery When:_____

Other:_____

Diagnostic Studies/Tests

- ◯ None
- ◯ Colonoscopy When:_____
- ◯ EGD When:_____
- ◯ ERCP When:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Separated
- ◯ Widowed

Alcohol

- ◯ None

Type	Number
◯ Never	
◯ Rarely	
◯ Daily	
◯ More than 2 days/week	
◯ Less than 2 days/week	
◯ I quit using alcohol	
◯ 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

Type	Started	Quit	Quantity	Frequency
◯ Cigarettes				
◯ Cigar				
◯ Pipe				
◯ Chewing Tobacco				