Digestive Disorders Associates

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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____
MRN:_____ Date Of Birth:_____
Age:_____ Notes:_____

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
☐ Unknown ☐ Patient declines to specify

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify

Sex
☐ Male ☐ Female ☐ Other

Preferred Language
☐ English ☐ Patient declines to specify Other:_____

Contact Preference
☐ Home Telephone ☐ Cell ☐ Patient declines to specify Other:_____

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies
☐ Penicillins ☐ Demerol ☐ Valium ☐ Amoxicillin ☐ Cipro
☐ Augmentin ☐ Latex ☐ Versed ☐ Morphine ☐ Aspirin
☐ Sulfa (Sulfonamide Antibiotics) Other:_____

Current Medications

☐ None

Name	Dose	How taken?

Immunizations

☐ None

☐ Hep A When:_____ ☐ Hep B When:_____ ☐ Flu When:_____ ☐ Pneumonia When:_____

Diagnostic Studies/Tests

☐ None

☐ Annual Labs When:_____ ☐ Colonoscopy When:_____ ☐ Duodenum Biopsy When:_____ ☐ EGD When:_____ ☐ ERCP When:_____

☐ Esophageal Biopsy When:_____ ☐ Liver Biopsy When:_____ ☐ Stomach Biopsy When:_____

Past or Present Medical Conditions

☐ None

Gastrointestinal	☐ None (Gastrointestinal)	☐ Acid Reflux	☐ Barrets Esophagus	☐ Cirrhosis
	☐ Crohn's Disease	☐ Diverticulitis	☐ Gallstones	☐ GERD
	☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C	☐ IBS
	☐ Liver Disease	☐ Other Hepatitis	☐ Pancreatitis	☐ Ulcer
	☐ Ulcerative Colitis	☐ Other Gastrointestinal:	☐ Sexually Transmitted Diseases	
General	☐ None (General)	☐ Alzheimer	☐ Anemia	☐ Anxiety disorder
	☐ Arthritis	☐ Asthma	☐ Atrial Fibrilation	☐ Back Pain (chronic)
	☐ Bipolar disorder	☐ Colon polyps	☐ C.O.P.D.	☐ Dementia
	☐ Depression	☐ Diabetes Mellitus	☐ Emphysema	☐ Fibromyalgia
	☐ Glaucoma	☐ Graves Disorder	☐ Heart Attack	☐ Hypertension
	☐ History of Blood Transfusions	☐ HIV	☐ Hyperthyroidism	☐ Hypothyroidism
	☐ Implanted defibrillator and/or pacemaker	☐ Kidney Disease	☐ Psyciatric Diagnoses	☐ Seizures
	☐ Stroke	☐ Tuberculosis	☐ Sleep apnea	☐ Other General:
Cancer	☐ None (Cancer)	☐ Lung	☐ Liver Cancer	☐ Esophageal Cancer
	☐ Prostate	☐ Skin (Melanoma)	☐ Skin Cancer (Basal/Squamous)	☐ Other Cancer:

Previous Procedures

- [ ] None

- [ ] Angioplasty When:_____
- [ ] Appendectomy When:_____
- [ ] C-Section When:_____
- [ ] Cardiac Surgery When:_____
- [ ] Cholecystectomy When:_____
- [ ] Colon Resection When:_____
- [ ] Coronary artery bypass surgery When:_____
- [ ] Gallbladder removed When:_____
- [ ] Gastric Band When:_____
- [ ] Gastric By-Pass When:_____
- [ ] Hemorrhoidectomy When:_____
- [ ] Hernia Repair When:_____
- [ ] Hysterectomy When:_____
- [ ] Joint Replacement When:_____
- [ ] Mastectomy When:_____
- [ ] Prostatectomy When:_____
- [ ] Pacemaker/Defibrillator When:_____
- [ ] Other: When:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Civil Union
- [ ] Unknown
- [ ] Other

Alcohol

- [ ] None
- [ ] Rarely
- [ ] Daily
- [ ] More than 2 days/week
- [ ] Less than 2 days/week
- [ ] I quit using alcohol

Type:_____

Caffeine

- [ ] None
- [ ] Intake:_____

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:_____

Drug Use

- [ ] None
- [ ] I am currently using recreational drugs
- [ ] I have used recreational drugs in the past
- [ ] I have been treated for substance abuse

Type:_____

Exercise

- [ ] None

Type Frequency

_____

Family Medical History

○ No knowledge of family history

No family history of ○ Colon cancer ○ Polyps

	Mother	Father	Sister	Brother	Grandmother	Grandfather
Diagnoses						
Ulcer disease	○	○	○	○	○	○
Stomach cancer	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○
Colitis	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○
Alcoholism	○	○	○	○	○	○
Heart trouble	○	○	○	○	○	○
High blood pressure	○	○	○	○	○	○
Stroke	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○

Review Of Systems

I consent to obtaining a history of my medications purchased at pharmacies.

◯ Yes ◯ No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

◯ Yes ◯ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

◯ Yes ◯ No

Reviewed with

◯ Patient ◯ Parent ◯ Guardian ◯ Not Present

Signature

Signature Date