Digestive Care Center

801 St. Mary's Drive, Ste 205 West
Evansville, IN 47714

Phone: (812) 477-6103
Fax: (812) 477-4897

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

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
- ☐ Prohibited by state law

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient declines to provide information
- ☐ Prohibited by state law

Preferred Language

- ☐ English
- ☐ Spanish

Other:_____

Contact Preference

- ☐ Telephone call

Other:_____

Immunizations

- ☐ None
- ☐ Hep A When:_____
- ☐ Hep B When:_____
- ☐ PPD When:_____
- ☐ Flu vaccine When:_____

Other:_____

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Penicillins
- ☐ Latex
- ☐ Sulfa (Sulfonamides)
- ☐ Contrast Dye
- ☐ Demerol
- ☐ fentanyl citrate (PF)
- ☐ Valium
- ☐ midazolam
- ☐ Propofol

Other:_____

Pharmacy

Name:_____

Current Medications

None

Name	Dose	How taken?

Diagnostic Studies/Tests

☐ None

☐ Upper GI X-Ray When:_____

☐ EGD When:_____

☐ Small Bowel X-Ray When:_____

☐ Camera Pill Examination When:_____

☐ Sigmoidoscopy When:_____

☐ Barium Enema When:_____

☐ Colonoscopy When:_____

☐ CT Scan When:_____

☐ Ultrasound When:_____

☐ Liver Biopsy When:_____

☐ Capsule Endoscopy When:_____

☐ ERCP When:_____

☐ EUS When:_____

Past or Present Medical Conditions

☐ None

☐ Diabetes When:_____

☐ Heart Disease When:_____

☐ High blood pressure When:_____

☐ Stroke/TIA/Seizure When:_____

☐ Congestive Heart Failure When:_____

☐ Atrial Fibrilation When:_____

☐ Heart Attack When:_____

☐ Coronary Artery Disease When:_____

☐ Angina When:_____

☐ Blood Transfusion When:_____

☐ Rheumatic Fever When:_____

☐ Mitral Valve Prolapse/MR When:_____

☐ Asthma When:_____

☐ Bronchitis When:_____

☐ Emphysema When:_____

☐ C.O.P.D. When:_____

☐ Anemia When:_____

☐ Acid Reflux When:_____

☐ Esophagitis When:_____

☐ Ulcers When:_____

☐ Gallbladder Disease When:_____

☐ Hepatitis When:_____

☐ Liver Disease When:_____

☐ Jaundice When:_____

☐ Colitis When:_____

☐ Crohn's Disease When:_____

☐ IBS When:_____

☐ Diverticulitis When:_____

☐ Hemorrhoids When:_____

☐ Colon polyps When:_____

☐ Disease of the Pancreas When:_____

☐ HIV/Aids When:_____

☐ Arthritis When:_____

☐ Kidney Disease When:_____

☐ Depression/Psychiatric Problems/Anxiety When:_____

☐ Thyroid disorder When:_____

☐ Cholesterol Problems When:_____

☐ Sleep apnea When:_____

☐ Other When:_____

Previous Procedures

☐ None

☐ Appendectomy When:_____

☐ C-Section When:_____

☐ Colon Resection When:_____

☐ Gallbladder removed When:_____

☐ Hiatal Hernia When:_____

☐ Hysterectomy When:_____

☐ Obesity Surgery When:_____

☐ Stomach/Bowel/ Colon Surgery When:_____

☐ Ulcer Surgery When:_____

☐ Uterus/Tubes/ Ovaries Surgery When:_____

☐ Heart Surgery When:_____

Other:_____

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 ☐ 2 days or less/week ☐ I quit using alcohol

Tobacco

Smoking Status

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker
☐ Smoker, current status unknown ☐ Unknown if ever smoked

	Type	Started	Quit	Quantity	Frequency
☐	Cigarettes				
☐	Cigar				
☐	Chewing Tobacco				

Drug Use

☐ None

☐ I have used recreational drugs in the past ☐ I am currently using recreational drugs ☐ I have been treated for substance abuse

Family Medical History

☐ No knowledge of family history

No family history of ☐ GI malignancies ☐ Inflamatory Bowel Disease

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son
Barrett's esophagus	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○
Colitis	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○
Liver Disease/Cirrhosis	○	○	○	○	○	○
Pancreatic Disease	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○
Stomach Ulcer Disease	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic — Yes / No
- ☐ None

	Yes	No
HIV exposure	☐	☐
persistent infections	☐	☐
strong allergic reactions or urticaria	☐	☐

Cardiovascular — Yes / No
- ☐ None

	Yes	No
angina/chest pain/w activity	☐	☐
irregular heart beat	☐	☐
shortness of breath	☐	☐
swelling in the legs	☐	☐

Constitutional — Yes / No
- ☐ None

	Yes	No
fatigue	☐	☐
fever	☐	☐
weight gain	☐	☐
weight loss	☐	☐
weight stable	☐	☐

ENMT — Yes / No
- ☐ None

	Yes	No
change in vision	☐	☐
hearing loss	☐	☐
glaucoma	☐	☐
mouth sores	☐	☐
ringing in ear	☐	☐
nose bleeds	☐	☐

Endocrine — Yes / No
- ☐ None

	Yes	No
thyroid problems	☐	☐
diabetes	☐	☐

Gastrointestinal — Yes / No
- ☐ None

	Yes	No
abdominal pain	☐	☐
blood in stool	☐	☐
constipation	☐	☐
change in bowel habits	☐	☐
diarrhea	☐	☐
heartburn	☐	☐
jaundice	☐	☐
hepatitis	☐	☐
pancreatitis	☐	☐
poor appetite	☐	☐
nausea	☐	☐
gas	☐	☐
vomiting	☐	☐
regurgitation	☐	☐

Genitourinary — Yes / No
- ☐ None

	Yes	No
blood in urine	☐	☐
heavy period	☐	☐
burning with urination	☐	☐
menopause	☐	☐
menstruating	☐	☐

Hematologic/Lymphatic — Yes / No
- ☐ None

	Yes	No
past transfusion	☐	☐
history of anemia	☐	☐
low platelets	☐	☐
on blood thinners	☐	☐

Integumentary — Yes / No
- ☐ None

	Yes	No
itching	☐	☐
rashes	☐	☐

Musculoskeletal — Yes / No
- ☐ None

	Yes	No
back pain	☐	☐
joint pain	☐	☐
swollen joints	☐	☐
muscle pain	☐	☐

Neurological — Yes / No
- ☐ None

	Yes	No
headaches	☐	☐
seizures	☐	☐
stroke	☐	☐

Psychiatric — Yes / No
- ☐ None

	Yes	No
chronic anxiety	☐	☐
depression	☐	☐

Respiratory — Yes / No
- ☐ None

	Yes	No
chronic cough	☐	☐
coughing up blood	☐	☐
positive TB test	☐	☐
wheezing	☐	☐

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

Signature

Signature Date