Open Access Patient Interview Form - Northeast Digestive Health Center

***Patient Information*:**

Name: _____

Date of Birth: _____

Primary Care Physician: _____

Insurance: _____

Policy #: _____

Group#: _____

Ins. Phone #: _____

***Race*:**

- ☐ White/Caucasian
- ☐ Black of 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

***Ethnicity*:**

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient declines to provide information

***Gender*:**

- ☐ Male
- ☐ Female
- ☐ Other

***Preferred Language*:**

- ☐ English
- ☐ Spanish

Other: _____

Preferred Pharmacy: _____

Location: _____

***Allergies*:**

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Eggs
- ☐ Soy
- ☐ Latex
- ☐ Fentanyl

Other:_____

Your E-mail address: _____

Your Mailing Address: _____

_____

_____

Best Phone Number: _____

Scheduling request: _____

Height: _____***feet*** _____***inches***

Weight: _____ ***pounds***

***Current Medication (including over the counter items)*:**

☐ **None**

Name *Dose* *How Taken*?

_____

_____

_____

_____

_____

_____

_____

***Past or Present Medical Conditions*:**

☐ **None**

***Heart Disease*:**

☐ Heart Valve Replacement When:_____ ☐ Heart Surgery When:_____

☐ Stent When:_____ ☐ Defibrillator When:_____

☐ Pacemaker When:_____ ☐ Atrial Fibrillation When:_____

☐ Stress Test When:_____ ☐ History of Heart Attack When:_____

Established with Cardiologist?:_____ Name of Cardiologist: _____

***Lung Disease*:**

☐ Sleep Apnea When:_____ ☐ Asthma/COPD When:_____

☐ CPAP use? When:_____ ☐ Oxygen Use When:_____

***Other Medical Details*:**

☐ Diabetes-Insulin When:_____ ☐ Diabetes-Oral Meds When:_____

☐ Glaucoma When:_____ ☐ Cirrhosis When:_____

☐ Kidney Problems When:_____ ☐ Seizures When:_____

☐ Thyroid Disorder When:_____ ☐ High Cholesterol When:_____

☐ Dialysis When:_____ ☐ Anemia When:_____

☐ Organ Transplant When:_____ ☐ History of CVA (Stroke, TIA) When:_____

☐ Blockage of arteries or veins(Anywhere) When:_____

***Key Procedure Related Details*:**

☐ Problems with anesthesia When:_____ What: _____

☐ Blood Thinner Use When:_____ What: _____

☐ Anesthesia Letter regarding Airway: _____

***GI Related Details*:**

☐ Acid Reflux/GERD When:_____ ☐ Colon Cancer When:_____

☐ Difficulty Swallowing When:_____ ☐ Hepatitis C When:_____

☐ Rectal Bleeding When:_____

***Previous Procedures*:**

☐ **None**

☐ Appendectomy Surgery When:_____
☐ Hysterectomy When:_____
☐ Gallbladder Surgery When:_____
☐ Abdominal Surgery When:_____
☐ Joint Replacement When:_____
☐ Hernia Repair When:_____
☐ Tubal Ligation When:_____
☐ Thyroid Surgery When:_____

☐ Colon Resection When:_____
☐ Gastric By-Pass When:_____
☐ Exploratory Laparoscopy When:_____
☐ Back Surgery When:_____
☐ Ectopic Pregnancy When:_____
☐ Bladder When:_____
☐ Mastectomy Rt ☐ or Left ☐ When:_____

Diagnostic Studies/Tests

☐ **None** ☐ **Previous Flexible Sigmoidoscopy**? When:_____ **Previous EGD**? When: _____
☐ **Previous Colonoscopy** When: _____ Where: _____ Findings:_____

***Social History*:**

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Alcohol	*Quantity*	*Number*	*Frequency*
☐ None			
☐ Beer			
☐ Wine			
☐ Liquor			

Tobacco/Smoking Status

☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker
☐ Never Smoker

Type	*Started*	*Quit*	*Quantity*	*Frequency*
☐ Cigarettes				
☐ Cigar				
☐ Pipe				
☐ Chewing Tobacco				
☐ Smokeless				

Illicit Drug Use

☐ None	*Started*	*Quit*	*Quantity*	*Frequency*
☐ Marijuana				
☐ Pills				
☐ Injectables				
☐ Cocaine				
☐ Other				

***Family Medical History*:**

☐ ***No knowledge of family history or I was adopted***

No family history of ☐ Colon Cancer ☐ Polyps

Does any of your immediate family have: Diagnoses	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Son	Daughter	Other
Bleeding Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Esophageal Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Bowel Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pancreatic Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Review Of Systems: Do you currently have any of the following symptoms?

	Yes	No
Cardiovascular ☐ **None**		
Chest pain	☐	☐
Irregular Heart Beat	☐	☐
Palpitations	☐	☐
Fainting or Passing Out	☐	☐
Constitutional ☐ **None**		
Weight Gain	☐	☐
Weight Loss	☐	☐
ENT ☐ **None**		
Difficulty Swallowing	☐	☐
Gastrointestinal ☐ **None**		
Abdominal Pain	☐	☐
Change in Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Heartburn	☐	☐
Rectal Bleeding	☐	☐
Vomiting	☐	☐
Bowel Movements ____ per day/week		

	Yes	No
Neurological ☐ **None**		
Dizziness	☐	☐
Fainting	☐	☐
Frequent Headaches	☐	☐
Migraine	☐	☐
Numbness or Tingling	☐	☐
Seizures	☐	☐
Tremors	☐	☐
Memory Loss	☐	☐
Psychiatric ☐ **None**		
Anxiety	☐	☐
Depression	☐	☐
Panic Attacks	☐	☐
Respiratory ☐ **None**		
Cough	☐	☐
Difficulty Breathing	☐	☐
Wheezing	☐	☐