ARIZONA DIGESTIVE HEALTH
powered by GI Alliance

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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____ MRN:_____

Date Of Birth:_____ Age:_____

Email
Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Contact Preference

☐ Cell phone ☐ Telephone call - Home ☐ Portal ☐ Patient declines to specify

Ethnicity

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

Race
Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Middle Eastern or North African (MENA) ☐ Other Race ☐ Unknown

☐ Patient declines to specify ☐ Prohibited by state law

Preferred Language

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

Sex

☐ Male ☐ Female ☐ Other ☐ Unknown

Gender Identity

☐ Male ☐ Female ☐ Transgender male/Trans man/Female-to-male ☐ Transgender female/Trans woman/Male-to-female ☐ Genderqueer, neither exclusively male nor female ☐ Chooses not to disclose Other:_____

Sexual Orientation

☐ Straight or heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual ☐ Don't know, Unknown ☐ Chooses not to disclose Other:_____

Allergies

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

Food ☐ Egg Derived ☐ Tree Nuts ☐ Shellfish Containing Products

Medication

☐ Aspirin ☐ Cipro ☐ Codeine ☐ Demerol ☐ Fentanyl ☐ Flagyl ☐ Iodine And Iodide Containing Products ☐ Iodinated Contrast Media

☐ Levaquin ☐ Morphine ☐ Penicillins ☐ Sulfa ☐ Latex, Natural Rubber Other:_____

Immunizations

☐ None

☐ Hep B vaccine When:_____ ☐ Hep A vaccine When:_____ ☐ Influenza When:_____ ☐ Influenza rejected When:_____ ☐ Pneumovax When:_____ ☐ Tetanus vaccine When:_____ ☐ Varicell/VZV vaccine When:_____ ☐ Moderna COVID-19 When:_____

☐ Pfizer COVID-19 When:_____ ☐ Janssen COVID-19 When:_____

Current Medications

☐ None

Name	Dose	How taken?

Pharmacy

Name Address Phone

Past Medical History

- [ ] None

Cancers:
- [ ] Colon
- [ ] Esophageal
- [ ] Liver
- [ ] Small intestine
- [ ] Stomach
- [ ] Kidney
- [ ] Pancreas
- [ ] Bladder
- [ ] Lymphoma
- [ ] Lung
- [ ] Skin
- [ ] Prostate
- [ ] Breast
- [ ] Cervical
- [ ] Ovarian
- [ ] Uterine

Liver:
- [ ] Cirrhosis of Liver
- [ ] Fatty Liver
- [ ] Hepatitis
- [ ] Hepatitis, autoimmune

Digestive:
- [ ] Acid Reflux
- [ ] Barrett's Esophagus
- [ ] Celiac sprue
- [ ] Colon polyps
- [ ] Crohn's disease
- [ ] Diverticulitis (infected)
- [ ] Diverticulosis
- [ ] H. pylori
- [ ] Irritable bowel syndrome
- [ ] Pancreatitis
- [ ] Ulcer
- [ ] Ulcerative Colitis

Other:

Miscellaneous:
- [ ] Anxiety/Panic attacks
- [ ] Anemia
- [ ] Arthritis
- [ ] Asthma
- [ ] Atrial Fibrillation
- [ ] Congestive heart failure (CHF)
- [ ] Coronary artery disease
- [ ] Depression
- [ ] Diabetes
- [ ] Emphysema
- [ ] Endometriosis
- [ ] Fibromyalgia
- [ ] Glaucoma
- [ ] Heart attack
- [ ] High blood pressure
- [ ] High Cholesterol
- [ ] HIV
- [ ] Kidney disease
- [ ] Lupus
- [ ] Osteopenia
- [ ] Osteoporosis
- [ ] Seizure disorder
- [ ] Sleep apnea
- [ ] Stroke/ (TIA)
- [ ] Hypothyroidism

Previous Gastroenterology Procedures

- [ ] None

- [ ] Colonoscopy When:
- [ ] EGD/Upper endoscopy When:
- [ ] Small Bowel Capsule When:
- [ ] ERCP When:
- [ ] EUS When:
- [ ] Liver Biopsy When:

Other:

Surgical Procedures

- [ ] None

- [ ] Appendectomy
- [ ] Bariatric surgery (for weight loss)
- [ ] Colon resection
- [ ] C-Section
- [ ] Coronary artery bypass
- [ ] Coronary/Stent
- [ ] Defibrillator
- [ ] Gallbladder removed
- [ ] Heart valve replacement/repair
- [ ] Hemorrhoidectomy
- [ ] Hernia surgery
- [ ] Hiatal hernia surgery(for reflux)
- [ ] Hysterectomy, partial (ovaries intact)
- [ ] Hysterectomy, total (ovaries removed)
- [ ] Joint surgery/replacement
- [ ] Liver transplant
- [ ] Mastectomy
- [ ] Pacemaker
- [ ] Prostatectomy
- [ ] Tonsillectomy
- [ ] Tubal ligation
- [ ] Ulcer Surgery

Social History

Occupation:

Marital Status
- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed

Alcohol
- [ ] None
- [ ] Less than 7 drinks per week
- [ ] More than 7 drinks per week
- [ ] I quit using alcohol

Caffeine
- [ ] None
- [ ] Occasionally
- [ ] Daily

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

- [ ] Cigar
- [ ] Chewing Tobacco
- [ ] Cigarettes
- [ ] Other

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

Exercise
- [ ] None

Type Quantity Frequency

- [ ] New

Family Medical History

- [ ] No knowledge of family history

No family history of

- ○ Celiac sprue
- ○ Crohn's disease
- ○ Ulcerative Colitis / IBD
- ○ Colon cancer
- ○ Liver disease
- ○ Colon polyps
- ○ Stomach cancer

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle	Other
Colon Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Crohn's disease/Ulcerative colitis	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Kidney cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Uterine cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Stomach cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Bladder cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pancreatic cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Ovarian cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Review Of Systems

Gastrointestinal

○ None	Y	N
abdominal pain	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
bloating/gas	○	○
heartburn/reflux	○	○
nausea	○	○
vomiting	○	○
blood in stool	○	○
difficulty swallowing	○	○
anorectal pain/itching	○	○
stool incontinence (leakage)	○	○
black tarry stools	○	○

Genitourinary

○ None	Y	N
dark urine	○	○
frequent urinary infections	○	○
frequent urination	○	○
blood in urine	○	○

Integumentary

○ None	Y	N
itching	○	○
yellowing of the skin	○	○
rashes	○	○

Cardiovascular

○ None	Y	N
chest pain	○	○
irregular heart beat	○	○
rapid heart rate/palpitations	○	○
hand/ankle swelling	○	○
heart murmur	○	○

Neurological

○ None	Y	N
frequent headaches	○	○
numbness or tingling	○	○
memory loss/confusion	○	○

Endocrine

○ None	Y	N
excessive thirst	○	○
cold intolerance	○	○

Constitutional

○ None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
night sweats	○	○
weight gain	○	○
weight loss	○	○
chills	○	○

Psychiatric

○ None	Y	N
anxiety	○	○
depression	○	○

ENMT

○ None	Y	N
sore throat	○	○
eye irritation	○	○
eye pain	○	○
eye redness	○	○
hoarseness	○	○
mouth sores	○	○

Hematologic/Lymphatic

○ None	Y	N
easy bruising	○	○
prolonged bleeding	○	○

Musculoskeletal

○ None	Y	N
back pain	○	○
joint pain	○	○

Respiratory

○ None	Y	N
frequent cough	○	○
wheezing	○	○
snoring	○	○
shortness of breath	○	○

Consent to Import Medication History

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

- ○ 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