ARIZONA DIGESTIVE HEALTH
powered by GI Alliance

Patient Interview Form

Patient Information

Your Name: _____ Date of Birth: _____ Today's Date: _____

Email: _____

Ethnicity

◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Patient declines to specify ◯ Unknown

Race

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

◯ Other Race ◯ Unknown ◯ Patient declines to specify

Preferred Language

◯ English ◯ Korean ◯ Spanish ◯ Patient declines to specify

Contact Preference

◯ Telephone call ◯ Patient declines to specify

Allergies

◯ Patient has no known allergies ◯ Patient has no known drug allergies

◯ Eggs ◯ Nuts ◯ Shellfish

◯ Aspirin ◯ Cipro ◯ Codeine ◯ Demerol ◯ Fentanyl

◯ Flagyl ◯ Iodine ◯ IV dye ◯ Levaquin ◯ Morphine

◯ Penicillins ◯ Sulfa ◯ Latex ◯ 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 (including herbs, vitamins, & over the counter medications)

◯ None

Name Dose How Taken?

_____

_____

_____

_____

_____

_____

_____

_____

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Pharmacy

Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Past or Present Medical Conditions

◯ None

Cancers:

◯ Colon ◯ Esophageal ◯ Liver ◯ Small intestine
◯ Stomach ◯ Kidney ◯ Pancreas ◯ Bladder
◯ Lymphoma ◯ Lung ◯ Skin ◯ Prostate
◯ Breast ◯ Cervical ◯ Ovarian ◯ Uterine

Liver:

◯ Fatty Liver ◯ Hepatitis ◯ Hepatitis, autoimmune

Digestive:

◯ Acid Reflux ◯ Barrett's Esophagus ◯ Celiac sprue ◯ Cirrhosis of liver
◯ Colon polyps ◯ Crohn's disease ◯ Diverticulitis ◯ Diverticulosis
◯ H. pylori ◯ Irritable bowel syndrome ◯ Pancreatitis ◯ Ulcer
◯ Ulcerative Colitis ◯ Other _____

Miscellaneous:

◯ Anxiety/Panic attacks ◯ Anemia ◯ Arthritis ◯ Asthma
◯ Atrial Fibrillation ◯ Congestive heart failure ◯ 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
◯ Thyroid disorder

Diagnostic Studies/Tests

◯ None

◯ Colonoscopy When: _____ ◯ EGD/Upper endoscopy When: _____ ◯ Small Bowel Capsule When: _____

Previous Procedures & Surgeries

◯ None

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

Social History

Occupation: _____

Marital Status

◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed
◯ Civil Union

Alcohol

◯ None
◯ Less than 7 drinks per week ◯ More than 7 drinks per week ◯ I quit using alcohol

Tobacco

◯ Current, Every Day Smoker ◯ Current, Some Day Smoker ◯ Former Smoker ◯ Never Smoked
◯ Smoker, Status Unknown ◯ Light tobacco smoker ◯ Heavy tobacco smoker ◯ Unknown if ever smoked
◯ Cigar ◯ Chewing tobacco

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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 family history of

- ◯ Celiac sprue
- ◯ Colon cancer
- ◯ Colon polyps
- ◯ Crohn's disease
- ◯ Liver disease
- ◯ Stomach cancer
- ◯ Ulcerative colitis/IBD

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	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Pancreatic cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Bladder cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Ovarian cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

◯ No knowledge of family history

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 preventative care and follow up care reminders.

◯ Yes ◯ No

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Review of Systems *(Please Select All Recent Symptoms)*

Gastrointestinal

	YES	NO
None		
Abdominal pain	◯	◯
Change in bowel habits	◯	◯
Constipation	◯	◯
Diarrhea	◯	◯
Bloating/Gas	◯	◯
Heartburn/Reflux	◯	◯
Nausea	◯	◯
Vomiting	◯	◯
Blood in stool	◯	◯
Difficulty swallowing	◯	◯
Anorectal pain/itching	◯	◯
Black tarry stools	◯	◯
Stool incontinence (leakage)	◯	◯

Genitourinary

	YES	NO
None		
Dark urine	◯	◯
Frequent urinary infections	◯	◯
Frequent urination	◯	◯
Blood in urine	◯	◯

Integumentary

	YES	NO
None		
Itching	◯	◯
Yellowing of the skin	◯	◯
Rashes	◯	◯

Cardiovascular

	YES	NO
None		
Chest pain	◯	◯
Irregular heart beat	◯	◯
Rapid heart rate/palpitations	◯	◯
Hand/ankle swelling	◯	◯
Heart murmur	◯	◯

Constitutional

	YES	NO
None		
Fatigue	◯	◯
Fever	◯	◯
Loss of appetite	◯	◯
Night Sweats	◯	◯
Weight gain	◯	◯
Weight loss	◯	◯
Chills	◯	◯

Psychiatric

	YES	NO
None		
Anxiety	◯	◯
Depression	◯	◯

ENMT

	YES	NO
None		
Sore throat	◯	◯
Eye irritation	◯	◯
Eye pain	◯	◯
Eye redness	◯	◯
Hoarseness	◯	◯
Mouth sores	◯	◯

Hematologic/Lymphatic

	YES	NO
None		
Easy bruising	◯	◯
Prolonged bleeding	◯	◯

Respiratory

	YES	NO
None		
Frequent cough	◯	◯
Shortness of breath	◯	◯
Wheezing	◯	◯
Snoring	◯	◯

Reviewed with

◯ Patient ◯ Parent ◯ Guardian ◯ Not Present