Florida Digestive Health Specialists

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Patient Interview Form

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Email (Personal):** _____

Pharmacy

Name: _____

Address: _____ **Phone:** _____

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies: ☐ **Yes** ☐ **No**

Current Medications and Supplements/Vitamins

☐ None

Name	Dose	How taken?

Allergies

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

☐ **Latex** ☐ **Iodine** ☐ **Propofol** **Other:** _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Civil Union ☐ Other

Alcohol

☐ None
☐ Type Alcoholic beverages Quantity: _____ Frequency: _____

Caffeine

☐ None Intake: _____

Tobacco/Smoking Status

☐ Current everyday smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker

☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker ☐ Unknown if ever smoked

Type _____ Started _____ Quit _____ Quantity _____ Frequency _____

Family Medical History

☐ No knowledge of family history
☐ No family history of colon cancer

Health Status	**Mother**	**Father**	**Sister**	**Brother**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Alive	○	○	○	○	○	○	○	○
Deceased/At Age	_____	_____	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____	_____	_____
Diagnoses								
Colon Cancer	○	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○	○
Hemophilia/Bleeding Disorders	○	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○	○
Pancreatitis	○	○	○	○	○	○	○	○
Ulcerative Colitis/IBD/ Crohn's Disease	○	○	○	○	○	○	○	○

Previous Procedures

☐ None

☐ EGD Date: _____ ☐ Colonoscopy Date: _____ ☐ Appendectomy Date: _____ ☐ Gallbladder Resection Date: _____ ☐ Hysterectomy Date: _____

Other: _____

_____

Past or Present Medical Conditions

☐ None

☐ Diabetes When: _____ ☐ Hypertension When:_____ ☐ Heart Disease When:_____ ☐ Stroke When: _____ Other: _____ When: _____

Review of Systems

Constitutional

☐ None	Y N
Fatigue	○○
Weight loss	○○

Eyes

☐ None	Y N
Glaucoma	○○

ENMT

☐ None	Y N
Hoarseness	○○
Sore throat	○○
Snoring	○○
Sleep apnea	○○

Cardiovascular

☐ None	Y N
Chest pain	○○
Shortness of breath with exercise	○○
Irregular heart beat	○○
Fainting	○○
Heart attack	○○
Stent	○○
Use of blood thinners	○○

Respiratory

☐ None	Y N
Asthma	○○
Cough	○○
Shortness of breath	○○
Wheezing	○○

Gastrointestinal

☐ None	Y N
Heartburn	○○
Abdominal Pain	○○
Nausea	○○
Vomiting	○○
Jaundice	○○
Change in bowel habits	○○
Constipation	○○
Diarrhea	○○
Hepatitis	○○
Hemorrhoids	○○
Narrow or flat stool	○○
Appetite problems	○○
Food intolerances	○○
History of Ulcers	○○
History of Polyps	○○
Rectal Bleeding	○○

Genitourinary

☐ None	Y N
Difficulty urinating	○○
Blood in urine	○○
Kidney dysfunction	○○

Integumentary

☐ None	Y N
Itching	○○
Rashes	○○

Neurological

☐ None	Y N
Dizziness	○○
Frequent headaches	○○
Seizures	○○
Stroke or TA	○○

Musculoskeletal

☐ None	Y N
Arthritis	○○
Back pain	○○
Anti-Inflammatory use	○○

Endocrine

☐ None	Y N
Thyroid disorder	○○
Diabetes	○○

Psychiatric

☐ None	Y N
Anxiety	○○
Depression	○○

Hematologic/Lymphatic

☐ None	Y N
Easy bruising	○○
Prolonged bleeding	○○
HX of anemia/blood transfusion	○○

Allergic/Immunologic

☐ None	Y N
HIV exposure	○○
Strong allergic reaction or hives	○○
Adverse reaction to sedation or anesthesia	○○

Signature:

_____ **Date:** _____