FINE DIGESTIVE HEALTH
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Patient Interview Form

Patient Information

Name: _____ Age: _____ Date of Birth: _____

Address: _____ Telephone: _____

Employer: _____

Emergency Contact: _____ Relation: _____ Contact Phone: _____

Email:

Please check one as your preferred email for communications

☐ Personal: _____ ☐ Work: _____

Referred by: ☐ Primary physician ☐ Google ☐ WebMD ☐ Facebook ☐ Friend/Family: Name _____

Race

Select one or more

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

☐ Other Race ☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

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

Sex

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ Spanish; Castilian ☐ Patient declines to specify ☐ Other _____

Contact Preference

☐ Letter ☐ Telephone call ☐ E-mail ☐ Text Message

Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Civil Union ☐ Unknown ☐ Other

Alcohol

☐ None

Type	Quantity	Number	Frequency
☐ Rarely			
☐ Daily			
☐ More than 2 days per week			
☐ Less than 2 days per week			
☐ I quit consuming alcohol			

Tobacco Smoking Status

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

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

Type	Started	Quit	Quantity	Frequency
☐ Chewing Tobacco				

Drug Use

☐ None

☐ Uses illicit drugs ☐ I quite using illicit drugs

Allergies

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

☐ Iodine ☐ Latex ☐ Penicillins ☐ Propofol ☐ Tape

☐ Sulfa ☐ Egg Other _____ Other _____ Other _____

Immunizations

☐ None

☐ Hep A, adult ☐ Hep B, adult ☐ PPD ☐ Pneumococcal

When _____ When _____ When _____ When _____

Diagnostic Studies/Tests

☐ None

☐ Abdominal U/S ☐ CT Abdomen ☐ MRI Abdomen ☐ Labs

When _____ When _____ When _____ When _____

Past or Present Medical Conditions

☐ None

☐ Anemia ☐ Asthma ☐ Atrial Fibrillation ☐ Person Hx of Cancer ☐ COPD

When _____ When _____ When _____ When _____ When _____

☐ Cirrhosis ☐ Colitis ☐ Colon Cancer ☐ Colon Polyps ☐ Crohn's Disease

When _____ When _____ When _____ When _____ When _____

☐ Depression ☐ Diabetes T-1 ☐ Diabetes T-2 ☐ Diverticulitis ☐ Gallstones

When _____ When _____ When _____ When _____ When _____

☐ GERD When _____
☐ Heart Attack When _____
☐ Hepatitis B When _____
☐ Hepatitis C When _____
☐ Hiatal Hernia When _____
☐ Hypertension When _____
☐ HIV/AIDS When _____
☐ Irritable Bowl Syndrome (IBS) When _____
☐ Kidney Disease When _____
☐ Lactose Intolerance When _____
☐ Pancreatitis When _____
☐ Paralysis When _____
☐ Rheumatoid Arthritis When _____
☐ Seizures When _____
☐ Stomach Ulcer When _____
☐ Sleep Apnea When _____
☐ Stroke When _____
☐ History of TB When _____
☐ Positive TB Skin Test When _____
☐ Fatty Liver When _____
☐ Kidney Stones When _____
☐ Renal Failure On Dialysis When _____
☐ Home Oxygen When _____

Other: _____ Other: _____ Other: _____

Previous Procedures

☐ None

☐ Appendectomy When _____
☐ CABG When _____
☐ C-Section When _____
☐ Cardiac Surgery When _____
☐ Colon Resection When _____
☐ Colonoscopy When _____
☐ Defibrillator When _____
☐ Pacemacker When _____
☐ EGD/Upper Endoscopy When _____
☐ ERCP When _____
☐ Gallbladder Removal When _____
☐ Hysterectomy (Vaginal) When _____
☐ Liver Biopsy When _____
☐ Obesity/Bariatric Surgery When _____
☐ Transplant Surgery When _____

Other: _____ Other: _____ Other: _____

Family Medical History

☐ No knowledge of family history

No family history of ☐ Colon Cancer ☐ Colon Polyps

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son
Colon Polyps	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Esophageal Cancer	☐	☐	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐
Liver Cancer	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐	☐
Gallbladder Disease	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐

Primary Care Doctor

Name Address Phone

Pharmacy

Name Address Phone

Current Medications

☐ None

Name	Dose	How taken?

Consent to Import Medication History

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

☐ Yes ☐ No

Consent to Share Data

I consent to having my medical and demographic information shared with other healthcare entities

☐ Yes ☐ No

Reminder Preference

I would like to receive preventative care and follow-up care reminders

☐ Yes ☐ No

Reviewed with

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

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

Signature

Signature Date