North Shore Digestive Medicine, P.C.
Farzad Forohar, M.D.
Practice Limited to Gastroenterology • Diplomat American Board of Gastroenterology
50 Route 111 • Suite 302 • Smithtown, New York 11787
Phone: (631) 724-5300 • Fax: (631) 724-5400

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

MRN:_____ Date Of Birth:_____

Age:_____ Notes:_____

Contact Preference

☐ Email ☐ Home Phone ☐ Work Phone ☐ Patient declines to specify Other:_____

Email

Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Sex

☐ Male ☐ Female ☐ Other

Race

Select one or more

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

☐ Unknown ☐ Patient declines to specify

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify

Preferred Language

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

Pharmacy

Name Address Phone

Allergies

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

☐ Latex ☐ Iodine Containing Drugs ☐ Iv Dye, Iodine Containing ☐ Penicillins Other:_____

Current Medications

☐ None

Name	Dose	How taken?

Immunizations

☐ None

☐ PPD When:_____ ☐ Hep A, adult When:_____ ☐ Hep A-Hep B When:_____ ☐ Hep B, adult When:_____

Diagnostic Studies/Tests

☐ None

☐ Colonoscopy When:_____ ☐ EGD When:_____ ☐ Stress Test When:_____ ☐ Sleep Study When:_____

Past or Present Medical Conditions

☐ None

☐ Acid Reflux When:_____ ☐ Anemia When:_____ ☐ Barrett's Esophagus When:_____ ☐ Colon polyp history When:_____ ☐ Hiatal hernia When:_____

☐ Irritable Bowel Syndrome When:_____ ☐ Diverticulitis When:_____ ☐ Diverticulosis When:_____ ☐ Crohn's Disease When:_____ ☐ Colitis When:_____

☐ Celiac Disease When:_____ ☐ Coronary Artery Disease When:_____ ☐ Bleeding Ulcer When:_____ ☐ Helicobacter pylori When:_____ ☐ Hemorrhoids When:_____

☐ Peptic ulcer disease When:_____ ☐ Ulcerative Colitis When:_____ ☐ Diabetes Mellitus, Insulin Dependent When:_____ ☐ Diabetes Mellitus, Non-Insulin Dependent When:_____ ☐ Hypertension When:_____

☐ Hyperthyroidism When:_____ ☐ Enlarged Prostate (BPH) When:_____ ☐ Hypothyroidism When:_____ Other:_____ Other:_____

Previous Procedures

☐ None

☐ Coronary Artery Bypass Graft (CABG) When:_____ ☐ Cardiac Cath - with stent placement When:_____ ☐ Cardiac Cath - without stent placement When:_____ ☐ Cholecystectomy - Laparoscopic When:_____ ☐ Colostomy When:_____

☐ Gastric Lap Band (banded gastroplasty) When:_____ ☐ Gastric Bypass - type unspecified When:_____ ☐ Hiatal Hernia Repair When:_____ ☐ Pacemaker Insertion When:_____ ☐ Hysterectomy - Abdominal When:_____

☐ Heart Valve Replacement When:_____ ☐ Defibulator When:_____ Other:_____ Other:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Separated
- ◯ Widowed
- ◯ Civil Union
- ◯ Unknown
- ◯ Other

Alcohol

- ◯ None

Type	Quantity	Number	Frequency

Caffeine

- ◯ None

Intake:_____ Intake:_____

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

Drug Use

- ◯ None

Type	Quantity	Number	Frequency

Exercise

- ◯ None

Type	Quantity	Number	Frequency

Family Medical History

○ No knowledge of family history

No family history of

○ Celiac sprue
○ Colon polyps
○ Ulcerative Colitis / IBD
○ Colon cancer
○ Liver disease

	Mother	Father	Sister	Brother	Aunt	Uncle	Grandmother	Grandfather
Health Status								
	○	○	○	○	○	○	○	○
Deceased/At Age	___	___	___	___	___	___	___	___
Diagnoses								
Colon Cancer	○	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○	○
Cancer of Esophagus, Stomach, or Pancreas	○	○	○	○	○	○	○	○
Diabetes Mellitus	○	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

◯ None	Y	N
HIV exposure	◯	◯

Cardiovascular

◯ None	Y	N
chest pain	◯	◯

Constitutional

◯ None	Y	N
weight loss	◯	◯

ENMT

◯ None	Y	N
difficulty swallowing	◯	◯

Eyes

◯ None	Y	N
double vision	◯	◯

Gastrointestinal

◯ None	Y	N
abdominal pain/bloating	◯	◯
abdominal swelling	◯	◯
change in bowel habits	◯	◯
constipation	◯	◯
diarrhea	◯	◯
gas	◯	◯
heartburn	◯	◯
jaundice	◯	◯
nausea	◯	◯
rectal bleeding	◯	◯
vomiting	◯	◯
difficulty swallowing	◯	◯

Genitourinary

◯ None	Y	N
hematuria	◯	◯
blood in urine	◯	◯

Hematologic/Lymphatic

◯ None	Y	N
prolonged bleeding	◯	◯

Integumentary

◯ None	Y	N
jaundice	◯	◯

Musculoskeletal

◯ None	Y	N
gout	◯	◯

Neurological

◯ None	Y	N
seizures	◯	◯

Psychiatric

◯ None	Y	N
anxiety	◯	◯
depression	◯	◯

Respiratory

◯ None	Y	N
asthma	◯	◯

Consent to Import Medication History

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

◯ Yes ◯ No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

◯ 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