North Shore Digestive Medicine, P.C.
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Patient Interview Form

Patient Information

First Name:______________________ Last Name:______________________

MRN:______________________ Date Of Birth:______________________

Contact Preference

- ⬭ Email
- ⬭ Telephone call-Work
- ⬭ Telephone call - Home
- ⬭ 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?

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:______________
- Bleediing 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:______________
- Defibrillator When:______________
- Other:______________
- Other:______________

Family Medical History

- [ ] No knowledge of family history

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

Social History

Occupation:________________________________ Number of Children:________________________________

Alcohol

- [ ] None

Type	Quantity	Number	Frequency

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Civil Union
- [ ] Unknown
- [ ] Other

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

Review Of Systems

Allergic/Immunologic
None — Y N
- HIV exposure
- persistent infections

Cardiovascular
None — Y N
- chest pain
- dyspnea with exercise
- irregular heart beat
- palpitations
- peripheral edema
- syncope

Constitutional
None — Y N
- fatigue
- fever
- loss of appetite
- malaise
- sweats
- weight gain
- weight loss

ENMT
None — Y N
- difficulty swallowing
- dizziness
- nose bleeds
- sore throat
- hearing loss

Endocrine
None — Y N
- excessive thirst
- hair loss
- heat intolerance

Eyes
None — Y N
- double vision
- loss of vision
- photophobia

Gastrointestinal
None — Y N
- abdominal pain/bloating
- abdominal swelling
- change in bowel habits
- constipation
- diarrhea
- gas
- heartburn
- jaundice
- nausea
- rectal bleeding
- stomach cramps
- vomiting
- difficulty swallowing

Genitourinary
None — Y N
- decrease in urine flow
- frequent urinary infections
- frequent urination
- hematuria
- nocturia
- blood in urine

Hematologic/Lymphatic
None — Y N
- bleeding gums or palpable lymph nodes
- easy bruising
- prolonged bleeding

Integumentary
None — Y N
- allergies
- dryness
- hives
- itching
- jaundice
- lesions
- rashes

Musculoskeletal
None — Y N
- arthritis
- back pain
- gout
- joint deformity
- joint pain
- muscle weakness
- stiffness

Neurological
None — Y N
- dizziness
- fainting
- frequent headaches
- migraine
- numbness or tingling
- seizures
- tremors
- vertigo
- memory loss

Psychiatric
None — Y N
- anxiety
- depression
- difficulty sleeping
- hallucinations
- nervousness
- panic attacks
- paranoia

Respiratory
None — Y N
- asthma
- cough
- dyspnea
- excessive sputum
- coughing up blood
- shortness of breath with exercise
- wheezing

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