sonoran
gastroenterology | endoscopy

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Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

MRN: _____ Date Of Birth: _____

Age: _____ Notes: _____

Email

Please check one as your preferred email for communications

☐ Personal: _____ ☐ Work: _____

Sex

☐ Male ☐ Female ☐ Other ☐ Unknown

Pharmacy

Name	Address	Phone

Current Medications

☐ None

Name	Dose	How taken?

Allergies

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

Past or Present Medical Conditions

- [ ] None

GASTROINTESTINAL	Acid reflux	Anal fistula	Anal Fissure	Barrett's Esophagus
	Esophageal Stricture	Esophageal Cancer	Hiatal hernia	Eosinophillic Esophagitis
	Peptic ulcer	H. pylori	Celiac Disease	Crohn's disease
	Ulcerative Colitis	Colon polyp	Colon cancer	Irritable Bowel Syndrome
	Diverticulosis	Diverticulitis	Fatty Liver	Hepatitis B
	Hepatitis C	Other Hepatitis	Liver enzymes abnormal	Cirrhosis
	Pancreatitis	Pancreatic cancer	Gallstones	Polyp of gallbladder
	Gastric Cancer	GI Bleed	Hemorrhoids	Alcohol abuse
GENERAL MEDICAL	Anemia	High blood pressure	Hypothyroidism	Elevated cholesterol
	Kidney disease	Kidney stone	Benign Prostatic Hyperplasia (BPH)	Interstitial Cystitis
	Diabetes	Osteopenia	Osteoporosis	HIV/AIDS
	Seizures	TIA	Stroke	Migraines
	Neuropathy	Vitamin B12 deficiency	Ulcer of mouth	Headaches
	Depression	Anxiety Disorder	Bipolar disorder	Panic disorder/attacks
	PTSD	Psoriasis	Melanoma	Skin Cancer
	Eczema	Rheumatoid	Osteoarthritis	Fibromyalgia
	Lupus	Gout	Scleroderma	Ankylosing spondylitis
	Conjuntivitis	Vertigo	Chronic back pain	Parkinson's
CARDIAC	Coronary Artery Disease	Coronary Artery Stents	Atrial Fibrillation	Arrhythmia
	Deep vein thrombosis	Chronic Anticoagulation	Aortic Aneurysm	Pacemaker
	Peripheral Vascular Disease			
PULMONARY	Asthma	Sleep Apnea	COPD	Emphysema
	Valley Fever	Pulmonary embolus	Oxygen Use	
CANCER	Anal Cancer	Bladder Cancer	Breast cancer	Endometrial Cancer
	Kidney Cancer	laryngeal cancer	Lung cancer	Ovarian Cancer
	Prostate Cancer	Testicular cancer	Thyroid Cancer (papillary)	Uterine Cancer

Previous Procedures

- [ ] None

Appendectomy	Back Surgery	Bladder Surgery	Brain Surgery	CABG
Carotid Endarterectomy	Cataract surgery	Cervical Surgery	Colon Resection	Cosmetic surgery
Gallbladder removed	D and C	Diverticulitis	Gastric By-Pass	Gastric Sleeve
Lap Band Surgery	Knee Surgery	Knee Replacement	Hip surgery	Hip Replacement
Hemorrhoidectomy	Hiatal hernia surgery	Partial hysterectomy	Hysterectomy-BSO	Lysis of adhesions
Prostatectomy	Shoulder Surgery	Tubal Ligation	Umbilical Hernia repair	Hernia Repair
Transplant	Lithotripsy	Tonsillectomy	Other: _____	

Diagnostic Studies/Tests

- [ ] None

☐ Upper Endoscopy When:_____

☐ Colonoscopy When:_____

☐ Capsule Endoscopy (Pill Camera) When:_____

☐ ERCP (endoscopic retrograde cholangiogram) When:_____

☐ CT Scan Abdomen When:_____

☐ Abdominal Ultrasound When:_____

☐ Cologuard Test When:_____

☐ Cardiac Stress Test When:_____

☐ Cardiac Catherization When:_____

Other:_____

Immunizations

☐ None

☐ Flu Shot When:_____

☐ Hepatitis B When:_____

☐ Pneumonia Vaccine When:_____

☐ COVID-19 When:_____

☐ TB skin Test When:_____

Social History

Occupation:_____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Civil Union ☐ Unknown ☐ Other

Alcohol

☐ None

Type	Quantity	Number	Frequency
☐ Wine			
☐ Beer			
☐ Liquor			

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

Type	Started	Quit	Quantity	Frequency

Drug Use

☐ None

Type	Quantity	Number	Frequency
☐ IV Drugs			
☐ Marijuana			

Exercise

☐ None

Type	Quantity	Number	Frequency
☐ ride bike			
☐ running			
☐ swimming			
☐ walking			

- [ ] golf
- [ ] cardio

Caffeine

- [ ] None

Intake:

Family Medical History

- [ ] No knowledge of family history

No family history of

- [ ] Celiac Disease
- [ ] Crohn's disease
- [ ] Gastric Cancer
- [ ] Pancreatic cancer
- [ ] Ulcerative Colitis
- [ ] Colon Cancer
- [ ] Esophageal Cancer
- [ ] Liver Disease
- [ ] Polyp of colon

Diagnoses

	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	First Cousin	Aunt	Uncle	Other
Colon Cancer	○	○	○	○	○	○	○	○	○	○	○	○
Colon polyp	○	○	○	○	○	○	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○	○	○	○	○	○	○
Cirrhosis of Liver	○	○	○	○	○	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

None	Y	N
persistent infections	○	○
strong allergic reactions or urticaria	○	○
Food allergies	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
chills	○	○
loss of appetite	○	○
malaise	○	○
weight gain	○	○
weight loss	○	○

ENMT

None	Y	N
difficulty swallowing	○	○
dizziness	○	○
nose bleeds	○	○
sore throat	○	○
loss of vision	○	○
hoarseness of voice	○	○
Post nasal drip	○	○

Endocrine

None	Y	N
excessive thirst	○	○
hair loss	○	○
Flushing	○	○

Cardiovascular

None	Y	N
chest pain	○	○
shortness of breath with exercise	○	○
irregular heart beat	○	○
palpitations	○	○
ankle swelling	○	○
fainting	○	○
shortness of breath with exercise	○	○

Respiratory

None	Y	N
cough	○	○
shortness of breath	○	○
excessive sputum	○	○
shortness of breath with exercise	○	○
wheezing	○	○
hemoptysis	○	○
coughing up blood	○	○

Gastrointestinal

None	Y	N
abdominal pain	○	○
abdominal swelling	○	○
Abdominal distention/bloating	○	○
stomach cramps	○	○
heartburn	○	○
reflux	○	○
gas	○	○
Indigestion	○	○
difficulty swallowing/dysphagia	○	○
solids stick with swallowing	○	○
liquids stick with swallowing	○	○
coughing with swallowing	○	○
post prandial fullness	○	○
nausea	○	○
vomiting	○	○
change in bowel habits	○	○
diarrhea	○	○
constipation	○	○
straining with defecation	○	○
rectal bleeding	○	○
wipe bleeding	○	○
Black Stools	○	○
Rectal Pain	○	○
Anal pain	○	○
Anal itching	○	○
Anal burning	○	○
Anal pressure	○	○
fecal incontinence	○	○
jaundice	○	○
Blood in stool	○	○

Genitourinary

None	Y	N
dark urine	○	○
frequent urination	○	○
urinary incontinence	○	○

Hematologic/Lymphatic

None	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○

Integumentary

None	Y	N
dryness	○	○
itching	○	○
rashes	○	○

Musculoskeletal

None	Y	N
joint pain	○	○
back pain	○	○
muscle weakness	○	○

Neurological

None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
headaches	○	○
numbness or tingling	○	○
tremors	○	○

Psychiatric

None	Y	N
anxiety	○	○
panic attacks	○	○
depression	○	○
paranoia	○	○
difficulty sleeping	○	○
hallucinations	○	○
nervousness	○	○

Constent to Import Medical 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

Signature

Signature Date