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

	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	First Cousin	Aunt	Uncle	Other
Diagnoses												
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