Desert Gastroenterology Consultants

Rancho Office:35900 Bob Hope Dr. Suite 275
Rancho Mirage, CA 92270 (760) 321-2500 fax (760) 321-5720

Patient Interview Form

Patient Information

First Name:________________ Last Name:________________

Date Of Birth:________________

Email

Personal:________________

Contact Preference

- ⬭ Home Phone
- ⬭ Cell phone
- ⬭ Email
- ⬭ Patient declines to specify

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
- ⬭ 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

Preferred Language

- ⬭ English
- ⬭ Korean
- ⬭ Spanish; Castilian
- ⬭ Patient declines to specify

Allergies

- ⬭ Patient has no known allergies
- ⬭ Patient has no known drug allergies

- ⬭ Penicillins
- ⬭ Aspirin
- ⬭ Vicodin
- ⬭ Codeine Sulfate
- ⬭ Propofol Analogues
- ⬭ Sulfa (Sulfonamide Antibiotics)
- ⬭ Versed
- ⬭ Iodine And Iodide Containing Products

Other:________________

Current Medications

- None

Name	Dose	How taken?

Past or Present Medical Conditions

- None
- Acid reflux
- Barrett's Esophagus
- Celiac disease
- Colon cancer
- Colon polyps
- Crohn's Disease
- Diverticulosis
- Fissure (anal)
- Hemorrhoids
- Hepatitis C
- Irritable bowel syndrome
- Liver disease
- Stomach ulcer
- Ulcerative colitis
- Anemia
- Anxiety disorder
- Arthritis
- Asthma
- Cardiac Stents
- Cancer
- Pacemaker/ defibrillator
- Heart Disease
- Depression
- Diabetes
- Fibromyalgia
- High cholesterol
- High blood pressure
- Kidney disease
- Sleep apnea
- Stroke
- Hyperthyroidism
- Hypothyroidism
- Taking blood thinners
- Hernia
- Use of oxygen therapy
- Constipation
- Other: ______________
- History of Sexually Transmitted Diseases (STDs)
- History of anal/rectal intercourse
- Do you know of any Children who would benefit from seeing a Pediatric Gastroenterologist?
- Would you be interested in participating in paid research trials?

Previous Procedures

- None
- Appendectomy
- Cardiac stent placement
- Colon, Bowel Resection
- Gastric Bypass
- Cholecystectomy
- Hysterectomy
- Heart valve replacement
- Joint replacement
- Lap Band
- Other: ______________

Diagnostic Studies/Tests

- None
- Colonoscopy When: ______________
- Upper endoscopy (EGD) When: ______________
- Other Recent Imaging/Labs When: ______________
- Other: ______________

Social History

Occupation: ______________________________ Number of Children: ______________________________

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed

Alcohol

- None
- Less than 7 drinks weekly, and no more than 3 drinks on any 1 occasion
- More than 7 drinks weekly, and/or more than 3 drinks on any 1 occasion
- Less than 14 drinks weekly and no more than 4 drinks on any 1 occasion
- More than 14 drinks weekly and/or more than 4 drinks on any 1 occasion
- Former alcohol abuse, now sober

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
- Past use of drugs
- Current use of drugs

Type:________________________________

Family Medical History

- No knowledge of family history

No family history of

- Colon cancer
- Colon polyps
- Gastrointestinal cancer
- Inflammatory Bowel Disease

Diagnoses	Mother	Father	Sister	Brother	Daughter	Daughter	Son	Son	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	First Cousin	Other
Celiac Disease																
Colon Cancer																
Breast Cancer																
Crohn's Disease																
Colon Polyps																
Diabetes																
Esophageal Cancer																
Ovarian Cancer																
Pancreatic Cancer																
Gastric Cancer																
Small Bowel Cancer																
Uterine Cancer																
Ulcerative Colitis																
Brain Cancer																
Hypertension/High Blood Pressure																
Kidney Cancer																
Fam hx malig gi tract																
Other:																

Review Of Systems

Gastrointestinal

⬭ None	Y	N
abdominal pain	○	○
abdominal distention, bloating	○	○
nighttime awakening from abdominal pain	○	○
abnormal bowel movements	○	○
diarrhea	○	○
constipation	○	○
loose stools	○	○
recent changes in bowel habits	○	○
rectal bleeding	○	○
black, tarry stools	○	○
rectal pain	○	○
fecal incontinence	○	○
heartburn	○	○
nausea	○	○
vomiting	○	○
belching	○	○
vomiting blood	○	○
gas	○	○

Allergic/Immunologic

⬭ None	Y	N
persistent infections	○	○

Cardiovascular

⬭ None	Y	N
chest pain	○	○
irregular heart beat	○	○
feeling like fainting when standing	○	○
heart murmur	○	○

Constitutional

⬭ None	Y	N
fatigue	○	○
fever	○	○
Chills	○	○
sweats	○	○
loss of appetite	○	○
weight loss	○	○

ENMT

⬭ None	Y	N
dysphagia	○	○
Non Pulsatile Ringing of the ears	○	○
Snoring	○	○
sinus pain	○	○
hoarseness	○	○

Endocrine

⬭ None	Y	N
excessive thirst	○	○
heat intolerance	○	○
cold intolerence	○	○
excessive urination	○	○

Eyes

⬭ None	Y	N
yellowing of eyes	○	○
redness of eyes	○	○

Genitourinary

⬭ None	Y	N
dark urine	○	○
difficulty urinating	○	○
frequent urination	○	○
urinary incontinence	○	○
urgency	○	○
heavy menstrual periods	○	○

Hematologic/Lymphatic

⬭ None	Y	N
easy bruising	○	○
prolonged bleeding	○	○
swollen lymph nodes	○	○
recent anemia	○	○

Integumentary

⬭ None	Y	N
itching	○	○
yellowing of skin	○	○
lesions	○	○
rashes	○	○

Musculoskeletal

⬭ None	Y	N
arthritis	○	○
back pain	○	○
joint pain	○	○
stiffness	○	○
swelling	○	○

Neurological

⬭ None	Y	N
dizziness	○	○
seizures	○	○
confusion	○	○

Psychiatric

⬭ None	Y	N
anxiety	○	○
depression	○	○
nervousness	○	○
agitation	○	○

Respiratory

⬭ None	Y	N
cough	○	○
shortness of breath	○	○
wheezing	○	○

Pharmacy

Name Address Phone

Consent to Import Medication History

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

⬭ 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