DIGESTIVE DISEASE GROUP
103 Liner Drive, Greenwood, SC 29646
864-227-3636

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____

Email

Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

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

Sex

☐ Male ☐ Female ☐ Other ☐ Unknown

Contact Preference

☐ Email ☐ Cell phone ☐ Telephone call - Home ☐ Patient declines to specify Other:_____

Preferred Language

☐ English ☐ Patient declines to specify

Pharmacy

Name Address Phone

Allergies

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

- [ ] Adhesive Tape
- [ ] Codeine Sulfate
- [ ] Erythromycin
- [ ] Penicillins
- [ ] Shellfish
- [ ] Containing
- [ ] Latex gloves
- [ ] Sulfa (Sulfonamide Antibiotics)
- [ ] Eggs
- [ ] Soy
- [ ] Demerol

Current Medications

- [ ] None

Name	Dose	How taken?

Immunizations

- [ ] None

- [ ] Flu vaccine When:_____
- [ ] Hep A When:_____
- [ ] Hep B When:_____
- [ ] Pneumovax When:_____
- [ ] TB skin test When:_____
- [ ] Covid-19 When:_____
- [ ] Other When:_____

Diagnostic Studies/Tests

- [ ] None

- [ ] Colonoscopy When:_____
- [ ] EGD When:_____
- [ ] CT Abdomen/Pelvis When:_____
- [ ] MRI Abdomen/Pelvis When:_____
- [ ] ERCP When:_____
- [ ] Capsule Endoscopy When:_____
- [ ] US Abdomen/pelvis When:_____

Previous Procedures

- [ ] None

- [ ] Abdominoplasty
- [ ] Appendectomy
- [ ] Abdominal aortic aneurysm (AAA) repair
- [ ] Back Surgery
- [ ] Bilateral Tubal Ligation (BTL)
- [ ] Cardiac Cath - with stent placement
- [ ] Carpal Tunnel Release (Left)
- [ ] Carpal Tunnel Release (Right)
- [ ] Cataract Surgery
- [ ] C-Section
- [ ] Colon resection
- [ ] Coronary Artery Bypass Graft (CABG)
- [ ] Defibrillator Placement
- [ ] Exploratory Laparoscopy
- [ ] Gallbladder removed
- [ ] Gastric Lap Band
- [ ] Gastric Bypass
- [ ] Heart valve replacement
- [ ] Hemorrhoidectomy
- [ ] Hemorrhoid banding
- [ ] Hernia Repair - Umbilical
- [ ] Hernia Repair - Inguinal
- [ ] Hiatal Hernia Repair
- [ ] Hip Replacement (Right)
- [ ] Hip Replacement (Left)
- [ ] Hysterectomy - Abdominal
- [ ] Knee Surgery (Left)
- [ ] Knee Surgery (Right)
- [ ] Mastectomy R Breast: DO NOT USE RIGHT ARM
- [ ] Mastectomy L Breast: DO NOT USE LEFT ARM

- ☐ Mastectomy, Both Breasts
- ☐ Pacemaker Insertion
- ☐ Shoulder Surgery (Right)
- ☐ Shoulder Surgery (Left)
- ☐ Small Bowel Resection
- ☐ Tonsillectomy and Adenoidectomy (T & A)
- ☐ Bilateral hip replacement
- ☐ Bilateral knee replacement
- ☐ Bilateral Shoulder
- ☐ Bilateral Hand
- ☐ Metal implants in the body (Specify-in other)

Other: _____

Past or Present Medical Conditions

☐ None

Gastroenterology/Hepatology

- ☐ Anemia
- ☐ Barrett's Esophagus
- ☐ Bowel Obstruction
- ☐ Celiac Disease
- ☐ Cirrhosis
- ☐ Colon polyp history
- ☐ Colon cancer
- ☐ Crohn's Disease
- ☐ Diverticulitis
- ☐ Dysphagia
- ☐ Esophageal dysphagia
- ☐ Fatty Liver
- ☐ Gastritis
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Hemorrhoids
- ☐ Hepatic encephalopathy
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Irritable Bowel Syndrome
- ☐ Nonalcoholic steatohepatitis (NASH)
- ☐ Pancreatitis
- ☐ Ulcerative Colitis
- ☐ Ulcer Disease

Other: _____ Other: _____ Other: _____

Cardiology

- ☐ Atrial Fibrillation
- ☐ Cardiac defibrillator
- ☐ Coronary Artery Disease
- ☐ Coronary Artery Stents
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ High blood pressure
- ☐ Pacemaker
- ☐ Stroke
- ☐ Transient Ischemic Attack
- ☐ Valvular heart disease
- ☐ Vascular Disease

Other: _____ Other: _____

Pulmonology

- ☐ Asthma
- ☐ Blood Clots (lung)
- ☐ Blood Clots (leg)
- ☐ C.O.P.D.
- ☐ Pulmonary emphysema
- ☐ Sleep apnea
- ☐ Wheezing

Other: _____

Other

- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Bipolar disorder
- ☐ Body piercings
- ☐ Breast cancer
- ☐ Current pregnancy
- ☐ Depression
- ☐ Diabetes Mellitus, Insulin Dependent (Type 1)
- ☐ Diabetes Mellitus, Non-Insulin Dependent (Type 2)
- ☐ Fibrositis / Fibromyalgia
- ☐ Gout
- ☐ HIV exposure
- ☐ HIV infection
- ☐ Hypothyroidism
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Lung cancer
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Seizures
- ☐ Skin Cancer
- ☐ Tattoos

Other: _____ Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

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

Alcohol

- ☐ None
- ☐ Occasionally
- ☐ Daily

Caffeine

- ☐ None
- ☐ Occasionally
- ☐ Daily

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

- ☐ Cigarettes
- ☐ Cigar
- ☐ Chewing Tobacco

Drug Use

- ☐ None
- ☐ IV or intranasal drugs
- ☐ Recreational

Exercise

- ☐ None
- ☐ Regular exercise
- ☐ Occasional exercise

Family Medical History

- ☐ No knowledge of family history

No family history of

- ☐ Celiac sprue
- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Crohn's disease
- ☐ Liver disease
- ☐ Stomach cancer
- ☐ Ulcerative Colitis / IBD

Health Status	Mother	Father	Sister	Brother	Grandmother	Grandfather
Deceased/At Age	○ ____	○ ____	○ ____	○ ____	○ ____	○ ____
Cause of Death	_____	_____	_____	_____	_____	_____
Diagnoses						
Celiac Disease	○	○	○	○	○	○

Colon cancer	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

None	Y	N
chest pain	○	○
dyspnea with exercise	○	○
irregular heart beat	○	○
orthopnea	○	○
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	○	○
ear pain	○	○
nasal obstruction	○	○
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	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
difficulty swallowing	○	○

Genitourinary

None	Y	N
dark urine	○	○
decrease in urine flow	○	○
dysuria	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○
impotence	○	○
nocturia	○	○
urethral discharge or incontinence	○	○

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	○	○
Shortness of Breath	○	○

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

Signature

Signature Date