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Digestive Health Specialists
OF THE SOUTHEAST

Gastroenterologists:
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Tyler P. Black, M.D.
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Adam L. Edwards, M.D.
Benjamin A. Hewitt, M.D.

Pathologist:
Beth M. Rutland, M.D.

Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____

Email
Personal: _____

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

Preferred Language

- ◯ English
- ◯ Patient declines to specify

Contact Preference

- ◯ Letter
- ◯ Telephone call
- ◯ e-mail
- ◯ Cell Phone
- ◯ Patient declines to specify

Other: _____

Reminder Preference

I would like to receive preventive care and follow up care reminders.

◯ Yes ◯ No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

◯ Yes ◯ No

Allergies

◯ Patient has no known allergies ◯ Patient has no known drug allergies

◯ Demerol ◯ IVP Dye ◯ Penicillin ◯ Propofol ◯ Codeine Sulfate

◯ Lortab ◯ Ambien ◯ Latex ◯ Versed ◯ Sulfa (Sulfonamide Antibiotics)

Other: _____ Other: _____

Immunizations

◯ None

◯ Flu Vaccine ◯ Hep B ◯ PPD/TB Skin ◯ Pneumonia Vaccine

When: _____ When: _____ When: _____ When: _____

Pharmacy

Name Address Phone

Consent to Import Medication History

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

◯ Yes ◯ No

Current Medications

◯ None

Name	Dose	How taken?

Diagnostic Studies/Tests

- ◯ None
- ◯ Abdominal Ultrasound — When _____
- ◯ Barium Swallow — When _____
- ◯ Colonoscopy — When _____
- ◯ CT Abdomen — When _____
- ◯ Hida Scan — When _____
- ◯ Sigmoidoscopy — When _____
- ◯ Test for Blood in Stool — When _____
- ◯ Upper Endoscopy/EGD — When _____
- ◯ Esophageal Motility Study — When _____
- ◯ Other — When _____

Previous Procedures

- ◯ None
- ◯ Appendectomy/Appendix — When _____
- ◯ Cholecystectomy/Gallbladder — When _____
- ◯ Colon Surgery — When _____
- ◯ Defibrillator — When _____
- ◯ Gastric Bypass — When _____
- ◯ Heart Bypass — When _____
- ◯ Heart Valve Replacement — When _____
- ◯ Hemorrhoid Surgery — When _____
- ◯ Hernia Repair — When _____
- ◯ Hysterectomy — When _____
- ◯ Pacemaker — When _____
- ◯ Paracentesis — When _____
- ◯ Prostate Surgery — When _____
- ◯ Other: _____ — When _____

Past or Present Medical Conditions

- ◯ None
- ◯ Anemia
- ◯ Anxiety/Depression
- ◯ Arthritis
- ◯ Atrial Fibrillation
- ◯ Barrett's Esophagus
- ◯ Bleeding Disorder
- ◯ Blood Clots (DVT)
- ◯ Cancer
- ◯ Celiac Disease
- ◯ Cirrhosis
- ◯ Colon Polyps
- ◯ Congestive Heart Failure
- ◯ Crohn's Disease
- ◯ Diabetes (Insulin Dependent)
- ◯ Diabetes (Non Insulin Dependent)
- ◯ Diverticulitis/ Diverticulosis
- ◯ Gallstones
- ◯ GERD or reflux disease
- ◯ GI Bleeding
- ◯ Heart Attack
- ◯ Hemorrhoids
- ◯ Hepatitis C
- ◯ High Blood Pressure
- ◯ HIV
- ◯ Irritable Bowel Syndrome
- ◯ Kidney Dialysis
- ◯ Liver Disease
- ◯ Pancreatitis
- ◯ Pulmonary Embolism
- ◯ Seizure Disorder
- ◯ Stroke
- ◯ Ulcer Disease
- ◯ Ulcerative Colitis
- Other
- Other

Social History

Occupation: _____

Marital Status

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Separated
- ◯ Widowed

Alcohol

- ◯ None

Type	Quantity	Number	Frequency

Caffeine

None

Intake:

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

Type	Quantity	Number	Frequency

Exercise

◯ None

Type	Quantity	Number	Frequency

Review of Systems

Constitutional	None	Yes	No
chronic fatigue	◯	◯	◯
fever	◯	◯	◯
weight loss	◯	◯	◯

Integumentary	None	Yes	No
bruising	◯	◯	◯
rash	◯	◯	◯

Hematologic/Lymphatic	None	Yes	No
anemia	◯	◯	◯
blood disorder	◯	◯	◯
easy bleeding	◯	◯	◯

Musculoskeletal	None	Yes	No
weakness	◯	◯	◯
back pain	◯	◯	◯
joint pain	◯	◯	◯

ENMT	None	Yes	No
deafness	◯	◯	◯
dizziness	◯	◯	◯
mouth or throat sores	◯	◯	◯
hoarseness	◯	◯	◯

Respiratory	None	Yes	No
asthma	◯	◯	◯
wheezing	◯	◯	◯
cough	◯	◯	◯
shortness of breath	◯	◯	◯

Cardiovascular	None	Yes	No
chest pain	◯	◯	◯
palpitations	◯	◯	◯

Gastrointestinal	None	Yes	No
diarrhea	◯	◯	◯
constipation	◯	◯	◯
heartburn	◯	◯	◯
stomach cramps	◯	◯	◯
nausea	◯	◯	◯
vomiting	◯	◯	◯
blood in stool	◯	◯	◯
blood on the tissue paper	◯	◯	◯
bloating	◯	◯	◯
jaundice	◯	◯	◯
gas	◯	◯	◯
trouble swallowing	◯	◯	◯
abdominal pain	◯	◯	◯

Genitourinary	None	Yes	No
increased urinary frequency	◯	◯	◯
change in urine color	◯	◯	◯
prostate problems	◯	◯	◯

Neurological	None	Yes	No
stroke	◯	◯	◯
numbness	◯	◯	◯

Psychiatric	None	Yes	No
bad nerves	◯	◯	◯
depression	◯	◯	◯

Family Medical History

No knowledge of family history

No family history of Colon Polyps

Health Status Cause of Death	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Maternal Grandfather
Diagnosis								
Gallstones	○	○	○	○	○	○	○	○
Pancreas problems	○	○	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○	○	○
Stomach ulcers	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○

Health Status Cause of Death	Parental Grandmother	Parental Grandfather	Aunt	Uncle	First Cousin
Diagnosis					
Gallstones	○	○	○	○	○
Pancreas problems	○	○	○	○	○
Liver disease	○	○	○	○	○
Colon polyps	○	○	○	○	○
Colon cancer	○	○	○	○	○
Crohn's disease	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○
Stomach ulcers	○	○	○	○	○
Other:	○	○	○	○	○