UTAH DIGESTIVE HEALTH INSTITUTE

Patient Interview Form

Date

E-mail _____

Patient Name (First Middle Last) _____ Date of Birth _____ Gender ◯M ◯F Phone Number _____ Height (Ft, In) _____ Age _____ WT. _____

Primary Symptom _____ Procedure Date _____ Surgeon/Doctor _____ Primary Care Doctor _____

Immunizations: ☐ Influenza Vaccine (Last 12 months) ☐ Pneumovax Vaccine

Past or Present Medical Conditions

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding / Blood Disorder
- ☐ Cancer-Colon
- ☐ Celiac Disease
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Epilepsy / Seizures
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ History of Polyps
- ☐ HIV/AIDS
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Kidney, Bladder or Prostate Problems
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lung Problems
- ☐ Mental Disability
- ☐ Mental Health Problems
- ☐ MS
- ☐ Osteoporosis
- ☐ Rheumatic Fever
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis / TB
- ☐ Use of Blood Thinner

Previous Procedures

Year		Year		Year	
_____	Abdominal Surgery	_____	Gallbladder Removed	_____	Polyp Removed from Intestine
_____	Appendectomy	_____	Gastric Surgery	_____	Prostate Surgery
_____	Breast Growth Removal	_____	Heart Catheterization/Surgery	_____	Thyroid Surgery
_____	Carpal Tunnel	_____	Heart Surgery	_____	Tonsillectomy
_____	Cataract Surgery	_____	Hernia Surgery	_____	Vasectomy
_____	Cesarean Section	_____	Hip Surgery	_____	Abdominal CT
_____	Colonoscopy	_____	Hysterectomy	_____	Abdominal Ultrasound
_____	Colon Surgery	_____	Knee Surgery	_____	Barium Enema
_____	D and C	_____	Nasal / Sinus Surgery	_____	UGI Series
_____	EGD	_____	Plastic Surgery	_____	Flexible Sigmoidoscopy

List Any Trauma / Broken Bones / Serious Accidents And Year They Occurred

_____

Social History

Occupation _____ Marital Status _____

◯ Yes ◯ No Do you exercise?

If yes, how often _____

◯ Yes ◯ No Do you use recreational drugs?

If yes, please list _____

Do you smoke? ◯ Yes ◯ No

☐ Smokeless ☐ Cigar ☐ Pipe ☐ Cigarette

Average number of packs per day? _____ Year quit _____

Number of years smoked? _____

Would you like help to quit? ◯ Yes ◯ No

Do you consume alcohol? ◯ Yes ◯ No

If Yes:

How much? _____

How often? _____

Have you ever thought you had a problem with drinking? ◯ Yes ◯ No

Do you consume caffeine? ◯ Yes ◯ No

Family Medical History

CHECK ANY ILLNESSES WHICH HAVE OCCURRED IN A BLOOD RELATED BROTHER (B), SISTER (S), MOTHER (M), FATHER (F), GRANDFATHER (GF) or GRANDMOTHER (GM)

Alcoholism / Substance Abuse	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM	Diabetes	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM
Alzheimer's / Dementia	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM	Emotional / Mental Illness / Suicide	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM
Cancer (Brain)	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM	High Blood Pressure	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM
Cancer (Breast)	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM	Heart Attack Prior to Age 55	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM
Cancer (Colon)	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM	Osteoporosis	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM
Cancer (Gastric)	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM	Polyps	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM
Cancer (Kidney)	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM	Stroke	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM
Cancer (Prostate)	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM	Tuberculosis	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM
Cancer (Other)	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM	Uterine / Ovarian Cancer	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM
Colitis	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM		
Crohn's	☐ M ☐ F ☐ B ☐ S ☐ GF ☐ GM		

Review of Symptoms

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Previous Cardiac Surgery
- ☐ Use of Blood Thinner

Constitutional
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Weightloss

ENMT
- ☐ Ear Ache or Vertigo
- ☐ Headache
- ☐ Hoarseness
- ☐ Vision Problems

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Abdominal Swelling
- ☐ Bloating
- ☐ Blood or Black Stools
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Heartburn
- ☐ Bright Red Blood Per Rectum
- ☐ Indigestion
- ☐ Jaundice
- ☐ Lack of Bowel Control
- ☐ Black Stools
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Rectal Pain
- ☐ Stomach Cramps
- ☐ Swallowing Difficulties
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Lack of Bladder Control
- ☐ Painful Urination or Burning

Integumentary
- ☐ Rashes or Irritation

Musculoskeletal
- ☐ Arthritis
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Stiffness

Neurological
- ☐ Numbness or Tingling
- ☐ Weakness or Paralysis

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ Nervousness
- ☐ Panic Attacks

Respiratory
- ☐ Cough
- ☐ Shortness of Breath

The conscious sedation medications we use have not been proven to be safe in pregnancy.
If you are pregnant or think you might be pregnant, please notify us.

THIS FACILITY WILL NOT BE RESPONSIBLE FOR PERSONAL BELONGINGS AND VALUABLES.
AS MANY BELONGINGS AND VALUABLES AS POSSIBLE SHOULD BE TAKEN HOME BY FAMILY MEMBERS.

x _____ _____ _____
PATIENT OR RESPONSIBLE PARTY SIGNATURE | DATE | RELATIONSHIP

FACILITY USE ONLY

_____ _____
Reviewed By Signature | Date