RIDGELINE ENDOSCOPY CENTER

REV 7/16

Patient Interview Form

Date

E-mail

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

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

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

Past or Present Medical Conditions

SCREENING COLONOSCOPY PATIENTS ONLY: PLEASE SKIP THE GASTROINTESTINAL SECTION

Cardiovascular
- ☐ Chest Pain
- ☐ Abnormal Heart Beat
- ☐ Use of Blood Thinner

Constitutional
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Exercise Intolerance

ENMT
- ☐ Ear Ache / Vertigo
- ☐ Headache
- ☐ Hoarsness
- ☐ Vision Problems
- ☐ Cataracts
- ☐ Glaucoma

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Abdominal Swelling
- ☐ Bloating
- ☐ Blood or Black Stools
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas / Heartburn / Indigestion
- ☐ Jaundice
- ☐ Lack of Bowel Control
- ☐ Nausea/Vomiting
- ☐ Rectal Bleeding
- ☐ Rectal Pain
- ☐ Stomach Cramps
- ☐ Swallowing Difficulties
- ☐ Vomiting Blood
- ☐ History of Polyps
- ☐ C. Difficile Toxin

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

Integumentary
- ☐ Rashes or Irritation

Musculoskeletal
- ☐ Arthritis
- ☐ Back Trouble / Pain
- ☐ Joint Pain
- ☐ MS
- ☐ Stiffness

Neurological
- ☐ Numbness or Tingling Weakness or Paralysis

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

Respiratory
- ☐ Shortness of Breath

Other
- ☐ Any Illness, Cold, Cough or Fever Within The Week
- ☐ Asthma
- ☐ Anemia
- ☐ Bleeding /Blood Disorder
- ☐ Broken Bones - Head, Neck, Spine or Restrictions?
- ☐ Cancer
- ☐ Cancer - Breast
- ☐ Cancer - Colon
- ☐ Celiac Disease
- ☐ Colitis
- ☐ Diabetes
- ☐ Difficulty Opening Mouth
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Hay fever
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Kidney, Bladder or Prostate Problems
- ☐ Kidney Stones
- ☐ Mental Health Problems
- ☐ Neurological Problems
- ☐ Osteoporosis
- ☐ Recent exposure to any communicable disease
- ☐ Rheumatic Fever
- ☐ Liver Disease
- ☐ Lung Problems
- ☐ Mental Disability
- ☐ Skin Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Stomach Problems
- ☐ Thyroid Disease
- ☐ Tuberculosis / TB
- ☐ Ulcers
- ☐ Other _____

Previous Procedures

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

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

Family History

LIST THE CAUSE OF DEATH FOR THOSE WHO HAVE DIED PRIOR TO AGE 50 (DO NOT INCLUDE ACCIDENTIAL DEATHS)

ARE YOU ADOPTED? ◯ Yes ◯ No

Father	Mother's Father	Father's Father
Mother	Mother's Mother	Father's Mother

(Please Turn Over)

(continued)

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

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 _____

◯ Yes ◯ No Do you wear contact Lenses?

◯ Yes ◯ No Do you have physical limitations?

◯ Yes ◯ No Do you need help from your doctor for a problem related to physical, verbal, or mental abuse?

◯ Yes ◯ No Do you have any environmental concerns? (room temperature, lighting, etc.)

◯ Yes ◯ No Are you at risk for AIDS / HIV / (homosexual, bisexual, multiple sex partners, needle drug use other than insulin)?

◯ Yes ◯ No Do you need help from your doctor for an issue related to drugs?

◯ Yes ◯ No Have you traveled outside the US (other than military)?

◯ Yes ◯ No Are you receiving treatment for glaucoma?

Do you have any of the following?

☐ False Teeth ☐ Chipped Teeth ☐ Braces ☐ Bridges

☐ Loose Teeth ☐ Caps/Crowns ☐ Retainers ☐ Body Piercing

Do you have special communication needs?

☐ Vision ☐ Hearing ☐ Language ☐ Speech

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

Advance Directives

◯ Yes ◯ No Do you have a living will?

◯ Yes ◯ No Do you have a durable/special power of attorney?

If yes, **where** is it located _____

◯ Yes ◯ No Do you have a medical treatment plan?

◯ Yes ◯ No Do you have a Physician Order for life Sustaining Treatment (POLST)?

If yes, **where** is it located _____

◯ Yes ◯ No Was a copy brought to the facility?

◯ Yes ◯ No Would you like more information?

Please go to http://www.hsdaas.ut.gov for more information on living wills

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