Seaford Endoscopy Center

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Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

Date Of Birth: _____

Email

Please check one as your preferred email for communications

☐ Personal: _____ ☐ Work: _____

Contact Preference

☐ Any method ☐ Patient Portal ☐ Letter/mail ☐ Home ☐ Cell Phone

☐ Patient declines to specify

Preferred Language

☐ English ☐ French ☐ Spanish; Castilian ☐ Patient declines to specify

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

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Unknown

Sex

☐ Male ☐ Female ☐ Other ☐ Unknown

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

Social History

Occupation:_____ Number of Children:_____

Alcohol

- ◯ None
- ◯ Current Use
- ◯ Former Alcohol Use
- ◯ Never used alcohol

Marital Status

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

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

Type	Started	Quit	Frequency
◯ Cigarettes			
◯ Other			

Caffeine

- ◯ None
- ◯ Coffee
- ◯ Tea
- ◯ Soda
- ◯ Energy Drinks

Drug Use

- ◯ None

Type	Frequency
◯ Recovering Substance Abuse	

Exercise

- ◯ None

Type	Quantity	Number	Frequency

Past or Present Medical Conditions

- ◯ None
- ◯ Admitted to hospital within past 90 days
- ◯ Anemia
- ◯ Anxiety
- ◯ Arthritis
- ◯ Asthma
- ◯ Atrial Fibrilation
- ◯ Autoimmune Disease
- ◯ Barrett's Esophagus
- ◯ Blood clots
- ◯ Cancer
- ◯ C-Difficile infection
- ◯ Celiac Disease
- ◯ Chronic headaches
- ◯ Colon cancer
- ◯ Chronic lung disease
- ◯ Colon polyps
- ◯ Congestive Heart Failure
- ◯ Contact with and (suspected) exposure to COVID-19 last 30 days
- ◯ Coronary Artery Disease
- ◯ Crohn's Disease
- ◯ Dementia/memory problems
- ◯ Diverticulitis infection of colon
- ◯ Diverticulosis (colon pockets)
- ◯ Diabetes-Type II
- ◯ Diabetes-Type I
- ◯ Enlarged Prostate (BPH)
- ◯ Environmental allergies
- ◯ Esophageal Reflux
- ◯ Esophageal Stricture
- ◯ Esophagitis
- ◯ Gall Bladder disease
- ◯ Glaucoma
- ◯ Heart Attack
- ◯ Hemorrhoids
- ◯ Hepatitis A

- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] Hiatal hernia
- [ ] Hypertension
- [ ] Low blood pressure
- [ ] High Cholesterol
- [ ] H Plyori Infection
- [ ] HIV/AIDS
- [ ] Irregular Heart beat
- [ ] Irritable Bowel Syndrome
- [ ] Kidney Disease
- [ ] Kidney Dialysis
- [ ] Lactose Intolerance
- [ ] Liver Disease
- [ ] Mental health condition
- [ ] MRSA or other Drug Resistant Infection
- [ ] Obstructive Sleep Apnea
- [ ] Pancreatitis
- [ ] Paralysis
- [ ] Parkinson's Disease
- [ ] Personal history of Covid-19
- [ ] Problems with Anesthesia
- [ ] Rectal cancer
- [ ] Seizures
- [ ] Stroke/TIA
- [ ] Stomach ulcer
- [ ] Substance use disorder
- [ ] Thyroid disorder
- [ ] Travel outside the US in past 30 days
- [ ] Tuberculosis exposure
- [ ] Ulcerative colitis

Previous Procedures

- [ ] None

- [ ] AICD/Defibrillator
- [ ] Amputations
- [ ] Appendectomy
- [ ] C-Section
- [ ] Cataract surgery
- [ ] Colon Resection
- [ ] Colostomy bag
- [ ] Esophagus Dilation
- [ ] Gallbladder Removed
- [ ] Heart Bypass Surgery
- [ ] Heart Stent/angioplasty
- [ ] Heart Valve Replacement
- [ ] Hemorrhoidectomy
- [ ] Hysterectomy
- [ ] Insertion of any metal, pins, screws
- [ ] Insertion of any ports, filters, shunts
- [ ] Joint Replacements
- [ ] Kidney procedure
- [ ] Liver Biopsy
- [ ] Lung surgery
- [ ] Mastectomy
- [ ] Obesity Surgery
- [ ] Pacemaker
- [ ] Feeding tube
- [ ] Prostate surgery
- [ ] Stomach Surgery
- [ ] Thyroid surgery
- [ ] Tonsillectomy
- [ ] Transplant Surgery
- [ ] Tubal Ligation

Other: _____

Family Medical History

- [ ] No knowledge of family history

No family history of

- [ ] Colon cancer
- [ ] Polyps

Diagnoses	Mother	Father	Sister	Brother
Family member with Colon Polyps	○	○	○	○
Family member with Colon Cancer before age 60	○	○	○	○
Family member with Colon Cancer after age 60	○	○	○	○
Family member with Rectal Cancer before age 60	○	○	○	○
Family member with Rectal Cancer after age 60	○	○	○	○
Familial multiple polyposis syndrome	○	○	○	○

Diagnostic Studies/Tests

- [ ] None

- [ ] Colonoscopy — When: _____
- [ ] Virtual CT Colonoscopy — When: _____
- [ ] Upper Endoscopy — When: _____
- [ ] Cologuard Test — When: _____
- [ ] Stool Test for blood — When: _____
- [ ] Recent GI X-Rays — When: _____
- [ ] Recent GI labs — When: _____
- [ ] Recent Emergency Room/Immediate Care for GI symptoms — When: _____
- [ ] Cardiac catheterization or stress test — When: _____
- [ ] Heart EKG — When: _____
- [ ] Sleep Apnea Study — When: _____

Immunizations

- [ ] None

- [ ] Flu vaccine — When: _____
- [ ] Have not had flu vaccine — When: _____
- [ ] Shingles — When: _____
- [ ] Have not had shingles vaccine — When: _____
- [ ] Hepatitis B vaccine — When: _____
- [ ] TB vaccine — When: _____
- [ ] Moderna COVID-19 — When: _____
- [ ] Pfizer COVID-19 — When: _____
- [ ] Johnson & Johnson COVID-19 — When: _____
- [ ] Pneumococcal pneumonia vaccine — When: _____
- [ ] Have not had pneumonia vaccine — When: _____

Allergies

- [ ] Patient has no known allergies
- [ ] Patient has no known drug allergies

- [ ] Propofol
- [ ] Midazolam (Versed)
- [ ] Opioids - Morphine Analogues
- [ ] Iodine And Iodide Containing Products
- [ ] Latex

Other: _____ Other: _____ Other: _____

Food
- [ ] Eggs
- [ ] Dairy
- [ ] Gluten — Other: _____
- [ ] Soy
- [ ] Nuts

Insect
- [ ] Bee stings — Other: _____

Environmental
- [ ] Mold — Other: _____
- [ ] Tree pollen
- [ ] Grass Pollen
- [ ] Weed Pollen

Pets
- [ ] Cats
- [ ] Dogs

Other: _____

Current Medications

- [ ] None

Name	Dose	How taken?

Consent to Import Medication History

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

Yes No

Pharmacy

Name Address Phone

Reviewed with

Patient Parent Guardian Not Present