Sullivan Digestive Center
For the personal, state-of-the-art care you need.

2204 Pavilion Drive, Suite 108
Kingsport, TN 37660
Phone: 423-392-6100
Fax: 423-392-0803

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

MRN:_____ Date Of Birth:_____

Age:_____ Notes:_____

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

☐ Letter ☐ Patient Portal ☐ None ☐ Telephone call ☐ Email

☐ Patient declines to specify Other:_____

Preferred Language

☐ English ☐ Patient declines to specify

Past or Present Medical Conditions

☐ None

☐ Covid 19 ☐ Adenocarcinoma ☐ Anemia ☐ Angina ☐ Asthma

☐ Autoimmune Disease ☐ Blood Disorder ☐ Cancer ☐ Chicken Pox ☐ Chlamydia

☐ Cirrhosis ☐ Congestive Heart Failure ☐ Constipation ☐ C.O.P.D. ☐ Crohn's Disease

☐ CVA/Stroke ☐ Diabetes Mellitus ☐ Diarrhea ☐ Defibrillator ☐ Esophageal Varicies

☐ Gonorrhea ☐ Heart Attack ☐ Heart Disease ☐ Heart Murmurs ☐ Hepatitis

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ HIV+ ☐ Hypertension

☐ Kidney Disease ☐ Lung Disease ☐ Measles ☐ Meningitis ☐ Mumps

Pacemaker	Prophylactic Antibiotics	Shingles	Sleep Apnea	Staph/MRSA
Strep Throat	Stroke or neurological Disease	Tuberculosis	Atrial Fibrilation	Oxygen dependent

Nasal Conditions	Deviated Septum	Nose Surgery/ Trauma

Allergies

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

- [ ] Adhesive Tape
- [ ] Codeine Sulfate
- [ ] Egg
- [ ] Latex
- [ ] Penicillins
- [ ] propofol
- [ ] Xylocaine
- [ ] Sulfa
- [ ] fentanyl
- [ ] Iodine-Iodine Containing
- [ ] Aspirin Low Dose
- [ ] morphine (bulk)

Current Medications

- [ ] None

Name	Dose	How taken?

Immunizations

- [ ] None

- [ ] Flu Vaccine When:_____
- [ ] Hep A When:_____
- [ ] Hep B When:_____
- [ ] Hep C When:_____
- [ ] OTHER When:_____
- [ ] Pneumonia Vaccine When:_____
- [ ] Covid-19 Vaccine When:_____

Diagnostic Studies/Tests

- [ ] None

- [ ] Abdominal U/S When:_____
- [ ] CT Abdomen When:_____
- [ ] CT chest When:_____
- [ ] CT Pelvis When:_____
- [ ] Colonoscopy When:_____
- [ ] Endoscopy When:_____
- [ ] Liver U/S When:_____
- [ ] Other When:_____
- [ ] Cologuard When:_____

Previous Procedures

- [ ] None

- [ ] Appendectomy When:_____
- [ ] C-Section When:_____
- [ ] CATH - Cardiac Stent When:_____
- [ ] Cholecystectomy When:_____
- [ ] Coronary artery bypass surgery When:_____
- [ ] Gastric By-Pass When:_____
- [ ] Hysterectomy When:_____
- [ ] Joint Replacment When:_____
- [ ] Mastectomy When:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Civil Union
- [ ] Unknown
- [ ] Other

Alcohol

- [ ] None

Type	Quantity	Number	Frequency
⬭ Beer			
⬭ Wine			
⬭ Liquor			
⬭ Other			

Caffeine

⬭ None

Intake:_____

Drug Use

⬭ None

Type	Quantity	Number	Frequency
⬭ Recreational Drugs			
⬭ IV Drugs			
⬭ Marijuana use			
⬭ 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	Quantity	Frequency
⬭ Cigarettes		Cigarettes / Week
⬭ Smokeless		Times / week
⬭ Chewing Tobacco		
⬭ Other		
⬭ Unknown		
⬭ Vaping		

Exercise

⬭ None

Type	Quantity	Number	Frequency
⬭ Family Hx of Colon Polyps			

Family Medical History

⬭ No knowledge of family history

No family history of ⬭ Family history of colon polyps

	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather
Health Status								
Deceased/At Age	○ ____	○ ____	○ ____	○ ____	○ ____	○ ____	○ ____	○ ____
Diagnoses								
Colon Cancer	○	○	○	○	○	○	○	○
Colon Polyp	○	○	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○
Other Cancers	○	○	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

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

Cardiovascular

None	Y	N
chest pain	○	○
heart attack	○	○
valve replacement	○	○
palpitations	○	○
irregular rhythm	○	○
leg swelling	○	○

Constitutional

None	Y	N
weight loss	○	○
weight gain	○	○
fever	○	○
chills	○	○
night sweats	○	○
fatigue	○	○
weakness	○	○

ENMT

None	Y	N
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
sore throat	○	○

Endocrine

None	Y	N
diabetes	○	○
thyroid disease	○	○

Eyes

None	Y	N
double vision	○	○
loss of vision	○	○
sensitivity to light	○	○
Macular Degeneration	○	○
Glaucoma	○	○
Cataracts	○	○

Gastrointestinal

None	Y	N
loss of appetite	○	○
excessive belching or gas	○	○
bloating	○	○
nausea	○	○
vomiting	○	○
acid reflux	○	○
trouble or pain swallowing	○	○
abdominal pain	○	○
diarrhea	○	○
constipation	○	○
rectal bleeding	○	○
heartburn	○	○

Genitourinary

None	Y	N
dark urine	○	○
decrease in urine flow	○	○
pain with urination	○	○
frequent urinary infections	○	○
frequent urination	○	○
blood in urine	○	○
impotence	○	○
urinate >2X @ night	○	○
urethral discharge or incontinence	○	○

Hematologic/Lymphatic

None	Y	N
anemia	○	○
bleeding problems	○	○
swollen lymph glands	○	○
easy bruising	○	○

Integumentary

None	Y	N
itching	○	○
rashes	○	○

Musculoskeletal

None	Y	N
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

None	Y	N
seizures	○	○
stroke	○	○
numbness or tingling	○	○
dizziness	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Respiratory

None	Y	N
asthma	○	○
pneumonia	○	○
chronic bronchitis	○	○
emphysema	○	○
wheezing	○	○
shortness of breath	○	○
cough	○	○
Bi-PAP	○	○
C-PAP	○	○

- change in bowel habits
- vomiting blood
- use of laxatives
- leaking stool or accidents
- hemorrhoids
- mucous in stool
- blood in stool
- indigestion
- jaundice
- dark urine

Pharmacy

Name Address Phone

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