CROHN'S & COLITIS FOUNDATION

IBD Patient Intake Data Sheet

DATE: ________________ **PROVIDER:** ____________________

MR#

Last name First name

Address City State Zip code

Home number: ( ) Work number: ( )

SS# DOB Age Gender Marital Status: M S W D

Emergency contact Relationship Phone ( )

Insurance

APPOINTMENT TYPE: ________NEW ______ Return ______ 2ND Opinion for Surgery

DIAGNOSIS: ____ Crohn's ___ Ulcerative Colitis ___ Indeterminate Colitis _____ not diagnosed/Unsure

Date of Diagnosis __________ **Age of Diagnosis** _______

Was patient referred to a specific Provider ***NO*** _____ **IF YES: Name of Provider** ________________________

REFERRING PROVIDER ***(Please √)*** _____***INTERNAL*** ***Name:*** ____

______ ***SELF REFERRED***

______ ***EXTERNAL (Fill in below)***

Referring provider information:

Name _______________________________ Office # ( ) _________________________ Fax # ( )
____

Address ________________________________ City _________________________ State _______ Zip code
____

Specialty of Referring Provider: ___General Medicine ____Family Practice ___Oncology ___Gastroenterology ___Other
____

PRIMARY CARE PROVIDER

Name _______________________________ Office # ( ) _________________________ Fax # ( )
____

Address ________________________________ City _________________________ State _______ Zip code
____

Specialty of Physician: ___General Medicine____ Family Practice ___Oncology ___Gastroenterology

___Other______________________

OTHER HEALTHCARE PROVIDERS

Counselor __ Psychologist ___ Psychiatrist ___ Other ___________________

733 Third Avenue, Suite 510 New York, NY 10017

Tel: 212-685-3440, Fax: 212-779-4098, E-mail: info@ccfa.org, Internet: www.ccfa.org

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<u>CURRENT SYMPTOMS</u> Check all that apply:

___ Abdominal Pain/Cramps ___ Urgency of stool ___ Diarrhea: ____ # per day
___ Pain with defecation ___ Constipation ___ Fistulae location: ____ perianal ___ skin ___ vaginal ___ bladder
___ Blood per rectum ___ leakage of stool ___ Perianal fistulae or abscess in the past ____ Hemorrhoids
___ Perineal discomfort ___ Nausea ___ Weight loss ___ # lbs. Weight Gain____ # lbs. In how many months? ____
___ Pneumaturia (air passing urine) ___ Vomiting ___ Muscle or joint pains
___ Fecaluria (stool in urine) ___ Fever: ____ F ____ Menstrual pain ____ menstrual irregularities
___ Obstructive symptoms of nausea, vomiting and abdominal pain

<u>MEDICAL HISTORY</u> **Check all that apply**

Asthma ___ Arthritis ___ Cancer ___ COPD ___ Depression ___ Diabetes ___ Hyperlipidemia ___ Hypertension
Obesity ___ Osteoporosis ___ Heart Attack ___ Stroke ___ Blood Clots ____ Anxiety ____ Insomnia _____

Additional Medical History or Other Medical Concerns:

____

____

____

____

____

<u>PAST SURIGAL HISTORY</u>

1. Surgery date and procedure:

   ____

   Where performed: ____

2. Surgery date and procedure:

   ____

   Where performed: ____

3. Surgery date and procedure:

   ____

   Where performed: ____

4. Surgery date and procedure:

   ____

   Where performed: ____

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IBD MEDICATIONS

Steroids: N ___ Y ___ Type: ___ Prednisone ____ Methyprednisolone ___ Budesonide (Entocort or Uceris) ____ Steroid Enemas

Dose: _______ mg/day last date taken: ______________________________

Other: ___ Sulfasalazine (SASP)

___ 5ASA: ___ Pentasa ___ Asacol ____ Lialda ___ Canasa supp

___ Imuran ___ 6MP Dose: _______ Frequency: _____________Date of Last dose: __________

___ Methotrexate: Oral ____ Injectable _____ Dose ______ Frequency_______ Date of last dose: ______________

___ Remicade ___ Humira ___ Tacrolimus ___ Natalizumab ___ (Cimzia) Certolizumab pegol ___ Vedolizumab

Dose: _________ Frequency _________ Date of Last dose ___________

___ Probiotics Name: ________________________

___Pain Medications ________ Type _________ Dose ____________ Frequency _____________

___ Other (herbs, vitamins, over the counter) ____

MEDICATIONS FOR OTHER ILLNESSES ____

____

Medication Allergies: ____

ADDITIONAL INFORMATIO:

Weight: _______ lbs. Height: _______' _______" If female, # of pregnancies _______ # of vaginal deliveries _______

Smoker: ___ No, never ___ Yes ____ Quit, last smoked __________ How many packs per day _____ Other_________

Interested in smoking cessation program: YES/NO

Recent Vaccinations/Screening: ___Influenza ___Hep B ___Td or Tdap ____ Pneumococcal___Zoster ___HPV

Recent work-up:

1. **Colonoscopy:** Date: __/__/__ Done here? __ Y __N If NO request outside slides be mailed here if diagnosed with UC, Cancer or dysplasia. Do not need slides for Crohn's disease unless a cancer noted.
2. **Small bowel:** Date: __/__/__ Done here? __ Y __N If NO need CD brought to appointment!
3. **Barium enema:** Date: __/__/__ Done here? __ Y __N If NO need CD brought to appointment!
4. **CT scan:** Date: __/__/__ done here? __ Y __N If NO need CD brought to appointment!
5. **MRE: Date: __/__/__** done here __ Y __N If NO need CD brought to appointment!

Check below how test results will be received:

_______ **Fax** _______ **Mail** ________ **Bring to Appointment** ***BRING CD OF TESTS TO APPOINTMENT***

Slides received and submitted to pathology: Date: __________________

Please check all items of concern that you have:

Availability of medications ___ Concerns with side effects of medications ____ Difficulty taking medications as directed ____ Insurance Coverage for medications___ Concerns related to coping with the disease/depression____ Interested in smoking cessation program____

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ADDITIONAL COMMENTS or CONCERNS:

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Updated by: Alyssa Swope, RN & Kim Kimberly Kearns, MS, ANP-BC. May 2023.

Reviewed by the Crohn's & Colitis Foundation's Nurse & Advanced Practice Committee.

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