CROHN'S & COLITIS FOUNDATION OF AMERICA
NATIONAL HEADQUARTERS

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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CURRENT SYMPTOMS 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

MEDICAL HISTORY **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:

_____

_____

_____

_____

_____

PAST SURIGAL HISTORY

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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