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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:______________________

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

Preferred Language

- ⬭ English
- ⬭ Spanish; Castilian
- ⬭ Patient declines to specify

Contact Preference

- ⬭ Letter
- ⬭ Cell phone
- ⬭ Portal
- ⬭ Patient declines to specify
- Other:______________

Pharmacy

____
Name Address Phone

Allergies

- ⬭ Patient has no known allergies
- ⬭ Patient has no known drug allergies
- ⬭ Adhesive Tape
- ⬭ Codeine Sulfate
- ⬭ Erythromycin
- ⬭ Penicillins
- ⬭ Shellfish
- ⬭ Iv Dye, Iodine Containing
- ⬭ Latex gloves
- Other:______________

Current Medications

- [ ] None

Name	Dose	How taken?

Immunizations

- [ ] None
- [ ] Flu vaccine (mm/dd/yyyy) When:________
- [ ] Hep A When:________
- [ ] Hep B When:________
- [ ] Pneumovax When:________
- [ ] TB skin test When:________
- [ ] Flu vaccine (mm/dd/yyyy) When:________
- [ ] COVID (Specify manufacturer) When:________
- [ ] COVID (Specify manufacturer) When:________

Diagnostic Studies/Tests

- [ ] None
- [ ] Colonoscopy When:________
- [ ] EGD When:________
- [ ] CT Abdomen/Pelvis When:________
- [ ] MRI Abdomen/Pelvis When:________
- [ ] ERCP When:________
- [ ] Gastric Emptying Study When:________
- [ ] Hemoccult When:________
- [ ] Cologuard When:________
- [ ] Flexible Sigmoidoscopy When:________

Previous Procedures

- [ ] None
- [ ] Gallbladder removed
- [ ] Appendectomy
- [ ] Colon resection
- [ ] Small Bowel Resection
- [ ] Exploratory Laparoscopy
- [ ] Gastric Bypass
- [ ] Gastric Lap Band
- [ ] Hemorrhoidectomy
- [ ] Hemorrhoid banding
- [ ] Abdominoplasty
- [ ] Hysterectomy - Abdominal
- [ ] Bilateral Tubal Ligation (BTL)
- [ ] Mastectomy L Breast
- [ ] Mastectomy R Breast
- [ ] Pacemaker Insertion
- [ ] Defibrillator Placement
- [ ] Coronary Artery Bypass Graft (CABG)
- [ ] Abdominal aortic aneurysm (AAA) repair
- [ ] Aortic Heart valve replacement
- [ ] Mirtral Heart valve replacement
- [ ] Cardiac Cath - with stent placement
- [ ] Joint Replacement
- [ ] Back Surgery
- [ ] Endoscopic Ultrasound

Other:________

Other:________

Past or Present Medical Conditions

- [ ] None

Gastroenterology/Hepatology

- [ ] Colon polyp history
- [ ] Colon cancer
- [ ] Irritable Bowel Syndrome
- [ ] Diverticulosis
- [ ] Crohn's Disease
- [ ] Ulcerative Colitis
- [ ] Gastroesophageal Reflux Disease (GERD)
- [ ] Barrett's Esophagus
- [ ] Ulcer Disease
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] Fatty Liver
- [ ] Cirrhosis
- [ ] Celiac Disease
- [ ] Bowel Obstruction
- [ ] Pancreatitis
- [ ] Anemia
- [ ] Esophageal Cancer

Other:________ Other:________

Cardiology

	⬭ Coronary Artery Disease	⬭ Congestive Heart Failure	⬭ Myocardial Infarction (Heart Attack)	⬭ High blood pressure
	⬭ Atrial Fibrillation	⬭ Vascular Disease	⬭ High Cholesterol	⬭ Stroke
	⬭ Transient Ischemic Attack (Mini-stroke)	⬭ Valvular heart disease	⬭ Pacemaker	⬭ Coronary Artery Stents
	Other:	Other:		
Pulmonology	⬭ C.O.P.D.	⬭ Asthma	⬭ Sleep apnea	⬭ Blood Clots (leg)
	⬭ Blood Clots (lung)	⬭ Wheezing	Other:	Other:
Other	⬭ Anxiety disorder	⬭ Arthritis	⬭ Bipolar disorder	⬭ Body piercings
	⬭ Breast cancer	⬭ Current pregnancy	⬭ Depression	⬭ Diabetes Mellitus, Insulin Dependent (Type 1)
	⬭ Diabetes Mellitus, Non-Insulin Dependent (Type 2)	⬭ Fibrositis / Fibromyalgia	⬭ Gout	⬭ HIV exposure
	⬭ HIV infection	⬭ Hypothyroidism	⬭ Kidney disease	⬭ Kidney stones
	⬭ Lung cancer	⬭ Ovarian Cancer	⬭ Prostate Cancer	⬭ Skin Cancer
	⬭ Seizures	⬭ Tattoos		

Social History

Occupation:________________ Number of Children:________________

Marital Status

⬭ Single ⬭ Married ⬭ Divorced ⬭ Separated ⬭ Widowed

⬭ Civil Union ⬭ Unknown ⬭ Other

Alcohol

⬭ None

⬭ Occasionally ⬭ Daily ⬭ Former Drinker

Caffeine

⬭ None

⬭ Occasionally ⬭ Daily

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	Quantity	Frequency
⬭ Cigarettes				
⬭ Cigar				
⬭ Chewing Tobacco				

Drug Use

⬭ None

Type	Quantity	Number	Frequency
⬭ IV or intranasal drugs			Times / month
⬭ Recreational			Times / month

Exercise

- [ ] None
- [ ] Regular exercise
- [ ] Occasional exercise

Family Medical History

- [ ] No knowledge of family history

No family history of

- [ ] Celiac sprue
- [ ] Colon polyps
- [ ] Liver disease
- [ ] Ulcerative Colitis / IBD
- [ ] Colon cancer
- [ ] Crohn's disease
- [ ] Stomach cancer

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather
Celiac Disease	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Esophageal cancer	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Review Of Systems

Cardiovascular

- [ ] None

	Y	N
chest pain	○	○
palpitations	○	○
high blood pressure	○	○
shortness of breath while lying down or sleeping	○	○

Constitutional

- [ ] None

	Y	N
fever	○	○

Genitourinary

- [ ] None

	Y	N
frequent urination	○	○
hematuria	○	○
impotence	○	○
urgent urination	○	○
difficulty holding urine/ accidents	○	○
burning with urination	○	○
sores	○	○
pain during intercourse	○	○

Psychiatric

- [ ] None

	Y	N
difficulty sleeping	○	○
nervousness	○	○
tension	○	○
manic symptoms	○	○
bad mood	○	○

Respiratory

- [ ] None

Y N

	Y	N
loss of appetite	◯	◯
weight loss	◯	◯
weakness	◯	◯
tire easily	◯	◯
light headedness	◯	◯

ENMT

◯ None

	Y	N
nose bleeds	◯	◯
sore throat	◯	◯
hearing loss	◯	◯
ringing sensation	◯	◯
sinus trouble	◯	◯
hay fever	◯	◯
sore mouth	◯	◯
hoarseness	◯	◯

Endocrine

◯ None

	Y	N
excessive thirst	◯	◯
heat intolerance	◯	◯
cold intolerance	◯	◯
excessive sweating	◯	◯
excessive hunger	◯	◯

Eyes

◯ None

	Y	N
yellow eyes	◯	◯
contact lenses/glasses	◯	◯

Gastrointestinal

◯ None

	Y	N
abdominal pain	◯	◯
abdominal swelling	◯	◯
constipation	◯	◯
diarrhea	◯	◯
nausea	◯	◯
vomiting	◯	◯
difficulty swallowing	◯	◯
milk intolerance	◯	◯
indigestion	◯	◯
vomiting blood	◯	◯
blood in stools	◯	◯
hard stools	◯	◯
use finger to evacuate stools	◯	◯

	Y	N
loss of interest in sex	◯	◯
past sexually transmitted infection	◯	◯
difficulty with periods	◯	◯
excessive bleeding during periods	◯	◯
menopause	◯	◯

Hematologic/Lymphatic

◯ None

	Y	N
easy bruising	◯	◯
prolonged bleeding	◯	◯
blood transfusions before 1992	◯	◯
transfusion reactions	◯	◯
anemia	◯	◯
excessive blood loss	◯	◯

Integumentary

◯ None

	Y	N
dryness	◯	◯
itching	◯	◯
lesions	◯	◯
rashes	◯	◯
tattoos	◯	◯
body piercing	◯	◯
leg ulcers	◯	◯
foot ulcers	◯	◯

Musculoskeletal

◯ None

	Y	N
back pain	◯	◯
joint pain	◯	◯
muscle pain	◯	◯
leg cramps	◯	◯

Neurological

◯ None

	Y	N
dizziness	◯	◯
fainting	◯	◯
frequent headaches	◯	◯
tremors	◯	◯
memory loss	◯	◯
blackouts	◯	◯
paralysis	◯	◯
numbness	◯	◯
confusion	◯	◯

	Y	N
asthma	◯	◯
cough	◯	◯
dyspnea	◯	◯
wheezing	◯	◯

Consent to Import Medication History

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

◯ 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