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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Today's Date:_____

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 ☐ Home Phone 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 ☐ Uses oxygen

Name / Dose / Form / How taken (eg. Tylenol 500mg 1 tablet by mouth twice daily as needed)

_____

_____

_____

_____

_____

_____

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:_____

Continues on next page

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				
☐ Cigars				
☐ 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

	Mother	Father	Sister	Brother	Grandmother	Grandfather
Diagnoses						
Celiac Disease	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Esophageal cancer	○	○	○	○	○	○
None of the above	○	○	○	○	○	○

Review Of Systems: Check the circle of the symptoms below you are having today

Cardiovascular
- Chest pain
- Palpitations
- High blood pressure
- Shortness of breath while lying down or sleeping

Constitutional
- Fever
- Loss of appetite
- Weight loss
- Weakness
- Tire easily
- Light headedness

ENMT
- Nose bleeds
- Sore throat
- Hearing loss
- Ringing sensation
- Sinus trouble
- Hay fever
- Sore mouth
- Hoarseness

Endocrine
- Excessive thirst
- Heat intolerance
- Cold intolerance
- Excessive sweating
- Excessive hunger

Eyes
- Yellow eyes
- Contact lenses/glasses

Gastrointestinal
- 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

Psychiatric
- Difficulty sleeping
- Nervousness
- Tension
- Manic Symptoms
- Bad mood

Respiratory
- Asthma
- Cough
- Dyspnea (shortness of breath)
- Wheezing

Genitourinary
- Frequent urination
- Hematuria
- Impotence
- Urgent urination
- Difficulty holding urine/accidents
- Burning with urination
- Sores
- Pain during intercourse
- Loss of interest in sex
- Past sexually transmitted infection
- Difficulty with periods
- Excessive bleeding during periods
- Menopause

Hematologic/lymphatic
- Easy bruising
- Prolonged bleeding
- Blood transfusions before 1992
- Transfusion reaction
- Anemia
- Excessive blood loss

Integumentary (skin)
- Dryness
- Itching
- Lesions
- Rashes
- Tattoos
- Body piercing
- Leg ulcers
- Foot ulcers

Musculoskeletal
- Back pain
- Joint pain
- Muscle pain
- Leg cramps

Neurological
- Dizziness
- Fainting
- Frequent headaches
- Tremors
- Memory loss
- Blackouts
- Paralysis
- Numbness
- Confusion

- None of the above symptoms

Medical Providers (Please list below the physicians currently treating your conditions)

Primary Care Physician: _____

Cardiologist: _____

Endocrinologist: _____

Transplant Physician: _____

Oncologist: _____

Nephrologist: _____

Other (please specify the condition): _____

_____

_____

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