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Patient Interview Form

Patient Information

First Name:________________ Last Name:________________

Date Of Birth:________________ Age:________________

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
- ◯ 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

Sex

- ◯ Male
- ◯ Female
- ◯ Other

Preferred Language

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

Contact Preference

- ◯ Letter
- ◯ Email
- ◯ Cell phone
- ◯ Telephone call - Home
- ◯ Patient declines to specify

Other:________

Pharmacy

____
Name Address Phone

Consent to Import Medication History

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

- Yes
- No

Current Medications

- None

Name | Dose

Allergies

- Patient has no known allergies
- Patient has no known drug allergies
- Codeine Sulfate
- Penicillins
- Sulfa (Sulfonamides)
- Sulfites
- Iodine Containing Drugs
- Eggs
- Latex

Other: ____________

Referring Physician:

Diagnostic Studies/Tests

- None
- Colonoscopy When: ____________
- EGD When: ____________
- CT Scan Abdomen/Pelvis When: ____________
- MRI Abdomen/Pelvis When: ____________
- Abdominal Ultrasound When: ____________

Past or Present Medical Conditions

- None

Gastroenterology / Hepatology

- Anemia
- Barrett's Esophagus
- Bowel Obstruction
- Celiac Disease
- Colon cancer
- Colon polyp history
- Colitis
- Cirrhosis
- Gallstones
- Gastroesophageal Reflux Disease (GERD)
- Gastric Ulcer
- Hepatitis B
- Hepatitis C
- Irritable Bowel Syndrome
- Pancreatitis
- Ulcerative Colitis

Other: ____________

Cardiology

- Arrhythmia
- Atrial Fibrillation
- Congestive Heart Failure
- Coronary Artery Disease
- Heart Attack
- Heart Murmurs
- High blood pressure
- High Cholesterol
- Transient Ischemic Attack
- Vascular Disease

Other: ____________

Pulmonology

- Asthma
- C.O.P.D.
- Lung cancer
- Emphysema
- Pneumonia

Other: ____________

Other

- Arthritis
- Anxiety disorder
- Bipolar disorder
- Gout
- Diabetes Mellitus, Insulin Dependent (Type 1)
- Diabetes Mellitus, Non-Insulin Dependent (Type 2)
- Depression
- HIV infection
- Hyperthyroidism
- Hypothyroidism
- Kidney stones
- Kidney disease
- Ovarian Cancer
- Prostate Cancer
- Skin Cancer
- Breast cancer
- Seizures

Other: ____________

Previous Procedures

- ⬭ None
- ⬭ Appendectomy
- ⬭ Colectomy (Colon Resection)
- ⬭ Cholecystectomy (Gallbladder removed)
- ⬭ Gastric Bypass
- ⬭ Gastric Lap Band
- ⬭ Tonsillectomy
- ⬭ Small Bowel Resection
- ⬭ Hemorrhoidectomy
- ⬭ Joint Replacement
- ⬭ Cataract Surgery
- ⬭ Hernia Repair
- ⬭ Coronary Artery Bypass Graft (CABG)
- ⬭ Cardiac Cath - with stent placement
- ⬭ Hysterectomy
- ⬭ Caeserean Section
- ⬭ D & C
- ⬭ Mastectomy
- ⬭ Vasectomy

Other: ____________

Social History

Occupation: ______________________ Number of Children: ______________________

Marital Status

- ⬭ Single
- ⬭ Married
- ⬭ Divorced
- ⬭ Separated
- ⬭ Widowed
- ⬭ Civil Union
- ⬭ Unknown
- ⬭ Other

Alcohol

- ⬭ None
- ⬭ Occasionally
- ⬭ Daily

Caffeine

- ⬭ None
- ⬭ Ocassionally
- ⬭ Daily
- ⬭ 1 cup/day
- ⬭ 2 cups/day
- ⬭ More than 2 cups/day

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
⬭ Recreational			

Exercise

- ⬭ None
- ⬭ Yes
- ⬭ No

Family Medical History

- ⬭ No knowledge of family history

No family history of

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

Review Of Systems

Allergic/Immunologic

	Y	N
◯ None		
HIV exposure	◯	◯
persistent infections	◯	◯

Cardiovascular

	Y	N
◯ None		
chest pain	◯	◯
dyspnea with exercise	◯	◯
irregular heart beat	◯	◯
palpitations	◯	◯
peripheral edema	◯	◯
syncope	◯	◯

Constitutional

	Y	N
◯ None		
fatigue	◯	◯
fever	◯	◯
weight loss	◯	◯

Gastrointestinal

	Y	N
◯ None		
abdominal pain	◯	◯
abdominal swelling	◯	◯
change in bowel habits	◯	◯
constipation	◯	◯
diarrhea	◯	◯
difficulty swallowing	◯	◯
gas	◯	◯
heartburn	◯	◯
jaundice	◯	◯
nausea	◯	◯
rectal bleeding	◯	◯
vomiting	◯	◯

Hematologic/Lymphatic

	Y	N
◯ None		
easy bruising	◯	◯
prolonged bleeding	◯	◯

Integumentary

	Y	N
◯ None		
hives	◯	◯
itching	◯	◯
jaundice	◯	◯

Musculoskeletal

	Y	N
◯ None		
back pain	◯	◯
joint pain	◯	◯
muscle weakness	◯	◯

Neurological

	Y	N
◯ None		
seizures	◯	◯
tremors	◯	◯

Psychiatric

	Y	N
◯ None		
anxiety	◯	◯
depression	◯	◯
difficulty sleeping	◯	◯

Respiratory

	Y	N
◯ None		
asthma	◯	◯
cough	◯	◯
dyspnea	◯	◯

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 ____________________