Patient Interview Form

Patient Information

First Name:________________________ Last Name:________________________

Date Of Birth:________________________

Email

Please check one as your preferred email for communications

- ⬭ Personal:________________________
- ⬭ Work:________________________

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?

Social History

Occupation:________________________ Number of Children:________________________

Alcohol

- ⬭ None

Type	Quantity	Number	Frequency
⬭ Occasionally			
⬭ Daily			

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

Review Of Systems

Allergic/Immunologic

None	Y	N
HIV exposure		
persistent infections		
strong allergic reactions or urticaria		

Cardiovascular

None	Y	N
chest pain		
shortness breath with exertion		
shortness breath when lying flat		
irregular heart beat		
palpitations		
ankle swelling		
syncope		

Constitutional

None	Y	N
fatigue		
fever		
loss of appetite		
malaise		
sweats		
weight gain		
weight loss		
chills		

ENMT

None	Y	N
difficulty swallowing		
nasal congestion		
nose bleeds		
sore throat		
hearing loss		
lump in throat		
post nasal drip		
sinus infection		
raspy voice/voice change		

Endocrine

None	Y	N
excessive thirst		
hair loss		
heat intolerance		
cold intolerance		
current menstruation		
menopause		

Eyes

None	Y	N
double vision		
loss of vision		
light sensitivity		

Gastrointestinal

None	Y	N
abdominal pain		
abdominal swelling\bloating		
change in bowel habits		
rectal bleeding		
hard stools		
diarrhea		
excessive gas		
yellow skin/eyes		
heartburn		
nausea		
vomiting		
feeling full fast after eating		
constipation		
excessive belching		
regurgitation		

Genitourinary

None	Y	N
dark urine		
burning on urination		
frequent urinary infections		
frequent urination		
blood in urine		
testicular pain		

Hematologic/Lymphatic

None	Y	N
bleeding gums or palpable lymph nodes		
easy bruising		
prolonged bleeding		
apirin use		
warfarin/coumadin use		
pradaxa/xarelto use		
plavix/brilinta use		

Integumentary

None	Y	N
hives		
itching		
lesions		
rashes		

Musculoskeletal

None	Y	N
arthritis		
back pain		
joint pain		
muscle weakness		
muscular cramps		
neck pain		

Neurological

None	Y	N
dizziness		
fainting		
frequent headaches		
migraine		
numbness or tingling		
seizures		
tremors		
vertigo (room spinning)		
memory loss		

Psychiatric

None	Y	N
anxiety		
depression		
difficulty sleeping		
nervousness		
panic attacks		
increased stress		
PTSD		
ADHD		
addiction/substance abuse		

Respiratory

None	Y	N
cough		
excessive sputum		
shortness of breath		
coughing up blood		
wheezing		

Reviewed with

Patient   Parent   Guardian   Not Present

Signature

Signature Date