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 ☐ Patient declines to specify

Contact Preference

☐ Letter ☐ Email ☐ Cell phone ☐ Telephone call-Work ☐ Telephone call - Home

☐ 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: _____ Other: _____ Other: _____ Other: _____ Other: _____

Current Medications

- [ ] None

Name	Dose	How taken?

Immunizations

- [ ] None
- [ ] Flu vaccine When: _____
- [ ] Hep A When: _____
- [ ] Hep B When: _____
- [ ] Pneumovax When: _____
- [ ] TB skin test When: _____

Diagnostic Studies/Tests

- [ ] None
- [ ] Colonoscopy When: _____
- [ ] EGD When: _____
- [ ] Abdominal Ultrasound When: _____
- [ ] CT Abdomen/Pelvis When: _____
- [ ] MRI Abdomen/Pelvis When: _____
- [ ] ERCP When: _____
- [ ] MRCP When: _____
- [ ] Esophageal Manometry When: _____
- [ ] Capsule Endoscopy When: _____
- [ ] Bone densitometry (DEXA) When: _____

Previous Procedures

- [ ] None
- [ ] Gallbladder removed When: _____
- [ ] Appendectomy When: _____
- [ ] Gastric Lap Band When: _____
- [ ] Gastric Bypass When: _____
- [ ] Gastric Bypass - Sleeve Gastrectomy When: _____
- [ ] Colon resection When: _____
- [ ] Small Bowel Resection When: _____
- [ ] Exploratory Laparoscopy When: _____
- [ ] Hemorrhoidectomy When: _____
- [ ] Hemorrhoid banding When: _____
- [ ] Hysterectomy - Abdominal When: _____
- [ ] Bilateral Tubal Ligation (BTL) When: _____
- [ ] Caeserean Section When: _____
- [ ] Pacemaker Insertion When: _____
- [ ] Defibrillator Placement When: _____
- [ ] Coronary Artery Bypass Graft (CABG) When: _____
- [ ] Abdominal aortic aneurysm (AAA) repair When: _____
- [ ] Heart valve replacement When: _____
- [ ] Cardiac Cath - with stent placement When: _____
- [ ] Joint Replacement When: _____
- [ ] Back Surgery When: _____

Other: _____ Other: _____

Past or Present Medical Conditions

☐ None

Gastroenterology/Hepatology

☐ Colon polyp history
☐ Irritable Bowel Syndrome
☐ Diverticulitis
☐ 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
☐ Eating disorder
☐ Colon cancer
☐ other GI cancer
☐ Gallstone
Other: _____
Other: _____
Other: _____
Other: _____

Cardiology

☐ Coronary Artery Disease
☐ Congestive Heart Failure
☐ Heart Attack
☐ High blood pressure
☐ Atrial Fibrillation
☐ Vascular Disease
☐ High Cholesterol
☐ Stroke
☐ Transient Ischemic Attack
☐ Valvular heart disease
Other: _____
Other: _____

Pulmonology

☐ C.O.P.D.
☐ Asthma
☐ Sleep apnea
☐ Blood Clots (leg)
☐ Blood Clots (lung)
☐ Pneumonia
Other: _____
Other: _____

Other

☐ COVID 19
☐ Current pregnancy
☐ Depression
☐ Anxiety disorder
☐ Bipolar disorder
☐ Body piercings
☐ diabetes type 1
☐ diabetes type 2
☐ Fibrositis / Fibromyalgia
☐ Gout
☐ HIV infection
☐ Hypothyroidism
☐ Kidney disease
☐ Kidney stones
☐ Seizures
☐ Tattoos
☐ Anticoagulation Therapy
☐ Breast cancer
☐ Lung cancer
☐ Prostate Cancer
☐ radiation therapy
☐ Ovarian Cancer
☐ Endometriosis
☐ endometrial cancer

Family Medical History

☐ No knowledge of family history

No family history of

☐ Celiac sprue
☐ Colon cancer
☐ Colon polyps
☐ Crohn's disease
☐ Liver disease
☐ Stomach cancer
☐ Ulcerative Colitis / IBD

Health Status	Mother	Father	Sister	Brother	Grandmother	Grandfather
Age/Date of Birth	_____	_____	_____	_____	_____	_____
Healthy	○	○	○	○	○	○
Ill	○	○	○	○	○	○
Seriously Ill	○	○	○	○	○	○

Disabled	○	○	○	○	○	○
In Remission	○	○	○	○	○	○
Alive	○	○	○	○	○	○
Deceased/At Age	○____	○____	○____	○____	○____	○____
Cause of Death	_____	_____	_____	_____	_____	_____

Diagnoses

Celiac Disease	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Endometrial carcinoma	○	○	○	○	○	○
Malignant neoplasm of uterus	○	○	○	○	○	○
Malignant tumor of cervix	○	○	○	○	○	○
Malignant neoplasm of gastrointestinal tract	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Social History

Occupation:_____ Number of Children:_____

Marital Status

○ Single ○ Married ○ Divorced ○ Separated ○ Widowed
○ Civil Union ○ Unknown ○ Other

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	○	○

Consent to Import Medication History

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

○ Yes ○ No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

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