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 ☐ 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

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:_____
- [ ] CT Abdomen/Pelvis When:_____
- [ ] MRI Abdomen/Pelvis When:_____
- [ ] ERCP 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 R Breast
- [ ] Pacemaker Insertion
- [ ] Defibrillator Placement
- [ ] Coronary Artery Bypass Graft (CABG)
- [ ] Abdominal aortic aneurysm (AAA) repair
- [ ] Heart valve replacement
- [ ] Cardiac Cath - with stent placement
- [ ] Joint Replacement
- [ ] Back Surgery
- [ ] Fibromyalgia

Other:_____ Other:_____

Past or Present Medical Conditions

- [ ] None

Gastroenterology/Hepatology

- [ ] Colon polyp history
- [ ] Colon cancer
- [ ] 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

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	☐ 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

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 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	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

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

Cardiovascular

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

Constitutional

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

ENMT

None	Y	N
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
sore throat	○	○
hearing loss	○	○

Endocrine

None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Eyes

None	Y	N
double vision	○	○
loss of vision	○	○
photophobia	○	○

Gastrointestinal

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

Genitourinary

None	Y	N
dark urine	○	○
decrease in urine flow	○	○
dysuria	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○
impotence	○	○
nocturia	○	○
urethral discharge or incontinence	○	○

Hematologic/Lymphatic

None	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○

Integumentary

None	Y	N
allergies	○	○
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○

Musculoskeletal

None	Y	N
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○
vertigo	○	○
memory loss	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Respiratory

None	Y	N
asthma	○	○
cough	○	○
dyspnea	○	○
excessive sputum	○	○
coughing up blood	○	○
shortness of breath with exercise	○	○
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