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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Notes:_____

Sex

☐ Male ☐ Female ☐ Other

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

Preferred Language

☐ English ☐ Russian ☐ Spanish; Castilian ☐ Patient declines to specify

Contact Preference

☐ Letter ☐ Email ☐ Patient declines to specify Other:_____

Pharmacy

Name Address Phone

Past or Present Medical Conditions

☐ None

Gastroenterology/Hepatology

☐ Colon cancer ☐ Colon polyp history ☐ Irritable Bowel Syndrome
☐ Diverticulitis ☐ Crohn's disease ☐ Ulcerative Colitis
☐ Gastroesophageal reflux disease (GERD) ☐ Barrett's Esophagus ☐ Hepatitis A
☐ Hepatitis B ☐ Hepatitis C ☐ Cirrhosis
☐ Celiac disease ☐ Bowelobstruction ☐ Pancreatitis
☐ Anemia ☐ Peptic ulcer disease ☐ Gallstones
Other: _____ Other: _____

Cardiovascular:

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

Pulmonology:

☐ C.O.P.D. ☐ Asthma ☐ Sleep apnea ☐ Blood Clots (Leg)
☐ Blood Clots (Lung)

Other:

☐ Anxiety disorder ☐ Arthritis ☐ Bipolar disorder ☐ Depression
☐ Diabetes Mellitus, Insulin Dependent (Type 1) ☐ Diabetes Mellitus, Non-Insulin Dependent (Type 2) ☐ Gout ☐ Hypothyroidism
☐ Kidney disease ☐ Kidney stones ☐ Seizures Other: _____

Previous Procedures

☐ None

☐ Abdominal aortic aneurysm (AAA) repair When: _____
☐ Appendectomy When: _____
☐ Bilateral Tubal Ligation (BTL) When: _____
☐ Cardiac Cath - with stent placement When: _____
☐ Colon resection When: _____
☐ Gallbladder removed When: _____
☐ Coronary Artery Bypass Graft (CABG) When: _____
☐ Defibrillator Placement When: _____
☐ Exploratory Laparoscopy When: _____
☐ Fundoplication - Nissen When: _____
☐ Gastric Lap Band When: _____
☐ Gastric Bypass When: _____
☐ Heart valve replacement When: _____
☐ Hemorrhoidectomy When: _____
☐ Hysterectomy - Abdominal When: _____
☐ Hiatal Hernia Repair When: _____
☐ Hernia Repair - Inguinal When: _____
☐ Hernia Repair - Umbilical When: _____
☐ Hernia Repair - Abdominal Wall When: _____
☐ Joint Replacement - site unspecified When: _____
☐ Lung Lobectomy When: _____
☐ Lumpectomy Breast When: _____
☐ Mastectomy R Breast When: _____
☐ Small Bowel Resection When: _____
☐ Vasectomy When: _____
☐ Colonoscopy When: _____
☐ EGD When: _____
Other: _____

Diagnostic Studies/Tests

☐ None

- ☐ ERCP When:_____
- ☐ MRI Abdomen/Pelvis When:_____
- ☐ Blood Tests When:_____
- ☐ CT Abdomen/Pelvis When:_____
- ☐ CT Chest When:_____
- ☐ Abdominal Ultrasound When:_____

Other:_____

Other:_____

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Adhesive Tape
- ☐ Aspirin
- ☐ Erythromycin
- ☐ Cephalosporins
- ☐ Penicillins
- ☐ Sulfa's
- ☐ Shellfish
- ☐ Iodine
- ☐ Latex

Other:_____

Other:_____

Current Medications

- ☐ None

Name	Dose	How taken?

Social History

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Civil Union
- ☐ Other

Alcohol

- ☐ None

Type	Quantity	Number	Frequency
☐ Beer			
☐ Wine			
☐ Hard Liquor			

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 Times / month
☐ Recreational			
☐ Marjuana			
☐ Street Drugs			
☐ Medications Not Prescribed to You			

Family Medical History

☐ No knowledge of family history

No family history of ☐ Colon Cancer

Health Status	Mother	Father	Sister	Brother	Daughter	Son
Alive	○	○	○	○	○	○
Deceased/At Age	○ ____	○ ____	○ ____	○ ____	○ ____	○ ____
Cause of Death	_____	_____	_____	_____	_____	_____
Diagnoses						
Barrett's Esophagus	○	○	○	○	○	○
Bleeding Disorders	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Coronary Artery Disease	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Lung cancer	○	○	○	○	○	○
Malignant Hyperthermia	○	○	○	○	○	○
Rectal Cancer	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Other:	○	○	○	○	○	○
Other:	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic	Y	N
Recurrent Infections	○	○

Cardiovascular	Y	N
Chest Pain	○	○
Palpitations	○	○
Swelling of Legs	○	○
Difficulty Climbing Stairs	○	○
Chest Pain When Resting	○	○
Chest Pain with Activity	○	○
Heart Murmur	○	○
Short of Breath - Exertion	○	○
Varicose Veins	○	○
High Blood Pressure	○	○

Constitutional	Y	N
Fatigue	○	○
Weight Gain	○	○
Weight Loss	○	○
Chills	○	○
Night Sweats	○	○

ENMT	Y	N
Nosebleeds	○	○
Sore Throat	○	○
Runny Nose	○	○
Sinus Infection	○	○
Bleeding Gums	○	○
Dental Problems	○	○
Dentures	○	○
Hoarseness	○	○
Voice Changes	○	○
Lumps	○	○
Throat Tenderness	○	○
Thyroid Troubles or Mass	○	○

Endocrine	Y	N
Increased Thirst	○	○
Heat Intolerance	○	○
Cold Intolerance	○	○
Increased Hunger	○	○
Thyroid Trouble	○	○
Weight Gain	○	○
Weight Loss	○	○

Eyes	Y	N
Blurry Vision	○	○
Glaucoma	○	○
Vision Changes	○	○

Gastrointestinal	Y	N
Abdominal Pain	○	○
Change in Bowel Habits	○	○
Constipation	○	○
Diarrhea	○	○
Heartburn	○	○
Nausea	○	○
Vomiting	○	○
Black Tarry Stools	○	○
Blood in Stool	○	○
Hernias	○	○
Swallowing Problems	○	○

Genitourinary	Y	N
Frequent Urinary Infections	○	○
Frequent Urination	○	○
Breast Discharge	○	○
Breast Lumps	○	○
Breast Pain	○	○
Breast Tenderness	○	○
Blood in Urine	○	○
Urine - Change in Color	○	○
Incontinence	○	○
Trouble Urinating	○	○
Male Genitalia - Hernias	○	○
Male Genitalia - Pain	○	○
Male Genitalia - Prostate Problems	○	○
Male Genitalia - Scrotal Masses	○	○
Female Genitalia - Birth Control	○	○
Female Genitalia - Change in Periods	○	○
Female Genitalia - Hernias	○	○
Female Genitalia - Lesions	○	○
Female Genitalia - Menopause	○	○

Hematologic/Lymphatic	Y	N
Easy Bruisability	○	○
Anemia	○	○
Bleeding Easily	○	○
Blood Clots	○	○
Transfusion Reaction	○	○

Integumentary	Y	N
Itching	○	○
Rashes	○	○
Eczema	○	○
Major Sunburns	○	○
Mole Increased in Size	○	○
MRSA Infection	○	○
Nail Appearance Change	○	○
Skin Color Change	○	○

Musculoskeletal	Y	N
Back Problems	○	○
Joint Pain	○	○
Muscle Pain	○	○

Neurological	Y	N
Dizziness	○	○
Fainting	○	○
Headaches	○	○
Numbness	○	○
Seizures	○	○
Tremors	○	○
memory loss	○	○
Balance Difficulty	○	○
Strokes	○	○
Head Injury	○	○

Psychiatric	Y	N
Anxiety	○	○
Depression	○	○
Suicidal Thoughts	○	○

Respiratory	Y	N
Cough	○	○
Blood in Sputum	○	○
Breathing Problems	○	○

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