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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

MRN:_____ Date Of Birth:_____

Age:_____

Email

Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Preferred Language

☐ English ☐ French ☐ Patient declines to specify

Contact Preference

☐ Patient Portal ☐ Home Number ☐ Cell Phone ☐ May leave a message on machine ☐ All of the Above

☐ Patient declines to specify

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify

Sex

☐ Male ☐ Female ☐ Other

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

Pharmacy

Name Address Phone

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

Drug Allergies: ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Penicillins

Sulfa | Latex | Surgical Tape | Other:

Current Medications

None

Name	Dose	How taken?

Immunizations

None

Flu Vaccine When: | Hepatitis B When: | Hepatitis A When: | Pneumonia When: | Shingles When:

Diagnostic Studies/Tests

None

Colonoscopy When: | EGD When: | Other:

Past or Present Medical Conditions

None

Anemia When: | Hepatitis A When: | Barrett's Esophagus When: | History colon polyps When: | Celiac Disease When:

Autoimmune Disease When: | Hepatitis B When: | GERD When: | History of Colon Cancer When: | Pancreatitis When:

Fatty liver When: | Hepatitis C When: | Gastric Ulcer When: | Crohn's Disease When: | Gallbladder Disease When:

Cirrhosis, Liver When: | HIV When: | Trouble swallowing When: | Ulcerative Colitis When: | Diverticular Disease When:

Other:

Other Medical Conditions:

Asthma When: | C.O.P.D. When: | Emphysema When: | Congestive Heart Failure When:

Sleep apnea When: | Home oxygen When: | Blood thinners When: | Hypertension-controlled by medication When:

Hypertension uncontrolled by medication When: | Pacemaker/ Defibrillator When: | Previous Heart Attack When: | Stroke When:

Artificial Heart Valve When: | Kidney disease When: | Dialysis When: | Seizures When:

Tuberculosis, Exposure When: | Diabetes Mellitus When: | High cholesterol When: | Mitral Valve Prolapse/MR When:

Glaucoma When: | HX of Cancer When: | Rheumatoid Arthritis When: | Other:

Previous Procedures

None

☐ Nissen Fundoplication When:_____	☐ Gastric By-Pass When:_____	☐ Appendectomy When:_____	☐ Gallbladder Surgery When:_____	☐ Colon Resection When:_____
When:_____	☐ Hernia Repair When:_____	Other:_____		

Other Surgical Procedures:	☐ C-Section When:_____	☐ Hysterectomy When:_____	☐ Heart stents When:_____	☐ Open heart surgery When:_____
	☐ Joint Replacement When:_____	Other:_____		

Social History

Number of Children:_____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Alcohol

☐ None

Type	Quantity	Frequency
☐ Beer		
☐ Hard liquor		
☐ Wine		

Caffeine

☐ None

☐ Coffee ☐ Energy Drinks ☐ Soda ☐ Tea ☐ Other

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

Drug Use

☐ None

☐ IV Drugs ☐ Other

Exercise

☐ None

☐ Daily ☐ 1-3 times per week ☐ 4-6 times per week ☐ Rarely

Family Medical History

☐ No knowledge of family history

No family history of ☐ Colon Cancer ☐ Colon Polyps ☐ Crohn's Disease ☐ Gallbladder Disease

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Aunt	Uncle	First Cousin	Other
Esophageal Cancer	○	○	○	○	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○	○	○	○	○	○
Inflammatory Bowel Disease	○	○	○	○	○	○	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○	○	○	○	○	○
Endometrial/Ovarian Cancer	○	○	○	○	○	○	○	○	○	○	○	○
Gallbladder Disease	○	○	○	○	○	○	○	○	○	○	○	○
Heart Disease/Hypertension	○	○	○	○	○	○	○	○	○	○	○	○
Stroke	○	○	○	○	○	○	○	○	○	○	○	○

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

Review of Systems

Genitourinary - (Women Only)

	YES
None	☐
Bleeding between periods	☐
Breast problems during menstrual periods	☐
Can you become pregnant?	☐
Current menstrual clots/cramping/flooding	☐
Miscarriages/stillborns	☐
Post-menopausal	☐
Problems with menstrual periods	☐
Vaginal itching or discharge	☐
Vaginal trauma	☐

Allergic/Immunologic

None	☐
Allergy shots	☐
Chemotherapy/Radiation	☐
Environmental allergies	☐
Food allergies	☐
Immune disorder	☐

Cardiovascular

None	☐
Ankle swelling	☐
Blood pressure	☐
Chest pain/angina	☐
Heart surgery/heart stent	☐
Leg cramps at night/pain	☐
Leg pain	☐
Heart disease or murmur	☐
Painful/numb/white/blue fingers	☐
Palpation (thumping/racing of heart)	☐

Constitutional

None	☐
Fatigue/lack of energy	☐
Health status	☐
Night sweats/fever/chills	☐
Weight gain	☐
Weight loss	☐

ENMT

None	☐
Blurred vision	☐
Canker sores/burning tongue	☐
Cataracts	☐
Contact lens	☐
Hearing impaired	☐
Hoarseness/sore throat	☐
Irritated eyes	☐
Nosebleeds	☐
Recent change in sight	☐
Ringing/buzzing/draining in ears	☐
Stuffy nose/post nasal drips/sinus attack	☐
Swollen glands in neck	☐
Trouble with gums/teeth	☐

Endocrine

None	☐
Changes in skin or hair or nails	☐
Diabetes	☐
Excessive thirst	☐
Excessive urination	☐
Glandular disorder	☐
Intolerance to heat/cold	☐
Thyroid disorder	☐

Gastrointestinal

	YES
None	☐
Abdominal pain	☐
Abdominal swelling/abdominal fluid	☐
Blood in stools	☐
Change in bowel movements	☐
Change/loss of appetite	☐
Choking or gagging when eating	☐
Constipation	☐
Diet restrictions	☐
Food allergies	☐
Frequent diarrhea	☐
Gallbladder disease	☐
Heartburn/reflux	☐
Hemorrhoids (piles)	☐
Hepatitis	☐
Jaundice/liver disease	☐
Nausea/upset stomach	☐
Painful bowel movements	☐
Pale/clay colored stools	☐
Rectal itching	☐
Rectal pain	☐
Trouble swallowing	☐
Unbalanced diet	☐
Vomiting	☐
Vomiting of blood	☐
Anal insertions	☐
Rectal trauma	☐
Hernias	☐

Genitourinary

None	☐
Blood in urine	☐
Difficulty passing urine	☐
Frequent urination	☐
High risk sexual activity	☐
Impotence	☐
Kidney stones/colic	☐
Kidney/bladder infections	☐
Painful/burning urination	☐
Prostate trouble	☐
Wake up at night to urinate	☐
Incontinence/leaky bladder	☐

Hematologic/Lymphatic

None	☐
Abnormal bleeding	☐
Anemia	☐
Bleeding or bruising tendencies	☐
Blood disorder	☐
Blood transfusion	☐
Cancer	☐
Enlarged glands	☐
Phlebitis/blood clots	☐
Slow to heal after cuts	☐
Tattoo/body piercings	☐

Integumentary

	YES
None	☐
Breast discharge/lump/pain	☐
Bruise easily	☐
Change in hair or nails	☐
Change in mole/scar	☐
Finger sensitivity to hot or cold	☐
Rash or itching	☐
Skin disorder	☐
Unusual itching	☐
Date of last mammogram	☐

Musculoskeletal

None	☐
Joint pain/stiffness/swelling	☐
Muscle cramps/weakness	☐
Neck pain/stiffness	☐
Severe backache/headache	☐
Date of last bone density	☐

Neurological

None	☐
Convulsions	☐
Difficulty talking	☐
Frequent or recurring headaches	☐
Hypersensitivity	☐
Light headed or dizziness	☐
Migraines/sick headaches	☐
Numbness or tingling sensation	☐
Paralysis	☐
Sick headaches	☐
Stroke	☐
Tremors	☐
Weakness	☐

Psychiatric

None	☐
Confusion	☐
Consulted psychiatrist	☐
Depression	☐
Difficulty making decisions	☐
Easily irritated or upset	☐
High-strung personality	☐
Insomnia	☐
Melancholy	☐
Memory loss	☐
Nervousness	☐
Recent stressful events	☐
Tenseness	☐
Trouble sleeping	☐
Uncontrollable anger	☐
Unpleasant work or home	☐
Worry excessively	☐

Respiratory

None	☐
Asthma	☐
Bloody sputum	☐
Cough, persisting	☐
Shortness of breath	☐
Sleep propped up at night	☐
Smothering spells at night	☐
Sputum (phlegm, mucus)	☐
Wheezing	☐
Tobacco use	☐

Signature

Signature Date