Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

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

☐ Unknown ☐ Patient declines to specify

Ethnicity

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

Sex

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ Patient declines to specify Other:_____

Contact Preference

☐ Letter ☐ Telephone call ☐ Cell Phone ☐ Patient Portal ☐ Patient declines to specify

Other:_____

Allergies

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

☐ Latex ☐ eggs ☐ Aspirin ☐ Sulfa (Sulfonamide Antibiotics) Other:_____

Immunizations

☐ None

☐ Hep B When:_____ ☐ Hep A When:_____ ☐ PPD When:_____ Other:_____

Diagnostic Studies/Tests

☐ None

- [ ] Colonoscopy When:_____
- [ ] Endoscopy When:_____
- [ ] ERCP When:_____
- [ ] CT Scan When:_____
- [ ] Sonogram When:_____
- [ ] MRI When:_____
- [ ] Blood Tests When:_____

Previous Procedures

- [ ] None

- [ ] Appendectomy When:_____
- [ ] Cardiac Stents When:_____
- [ ] Cataracts When:_____
- [ ] Colon Resection When:_____
- [ ] C-Section When:_____
- [ ] D and C When:_____
- [ ] Gallbladder removed When:_____
- [ ] Heart Surgery (type)_____ When:_____
- [ ] Hernia Repair When:_____
- [ ] Hysterectomy When:_____
- [ ] Joint replacement When:_____
- [ ] Tonsillectomy When:_____
- [ ] Tubal Ligation When:_____
- [ ] Vasectomy When:_____
- [ ] Weight Loss Surgery When:_____
- [ ] other operation not listed When:_____

Past or Present Medical Conditions

- [ ] None

- [ ] Anemia When:_____
- [ ] Anxiety disorder When:_____
- [ ] Arthritis When:_____
- [ ] Asthma When:_____
- [ ] Barretts Esophagus When:_____
- [ ] Bleeding Disorder When:_____
- [ ] Breast cancer When:_____
- [ ] Celiac Sprue When:_____
- [ ] Chest Pain When:_____
- [ ] Cirrhosis When:_____
- [ ] Colon cancer When:_____
- [ ] Colon polyps When:_____
- [ ] C.O.P.D. When:_____
- [ ] Crohn's Disease When:_____
- [ ] Defibrilator When:_____
- [ ] Depression When:_____
- [ ] Diabetes Mellitus When:_____
- [ ] Difficulty Swallowing When:_____
- [ ] Diverticular Disease When:_____
- [ ] Esophageal Cancer When:_____
- [ ] Gallstones When:_____
- [ ] Glaucoma When:_____
- [ ] Heart Attack _____(date) When:_____
- [ ] Heart Disease When:_____
- [ ] Heartburn/Reflux When:_____
- [ ] Hepatitis _____ (type) When:_____
- [ ] Hiatal hernia When:_____
- [ ] High blood pressure When:_____
- [ ] High Cholesterol When:_____
- [ ] Irritable Bowel Syndrome When:_____
- [ ] Kidney disease When:_____
- [ ] Pace Maker When:_____
- [ ] Pancreatitis When:_____
- [ ] Prostate Cancer When:_____
- [ ] Sleep apnea When:_____
- [ ] Stroke / TIA When:_____
- [ ] Thyroid disease When:_____
- [ ] Ulcerative Colitis When:_____
- [ ] Ulcers When:_____

Social History

Alcohol

- [ ] None

Type	Quantity	Number	Frequency

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Widowed

Caffeine

- [ ] None

Intake:_____

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

Type	Quantity	Number	Frequency

Family Medical History

No knowledge of family history

No family history of Family history of colon cancer Family history of colon polyps

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other	Other	Other	Other	Other	Other	Other	Other	Other	Other	Other	Other
Diagnoses																				
Breast Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Gallbladder Disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Throat Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Thyroid Disorder	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
Skin rashes or itching	○	○

Cardiovascular

None	Y	N
chest pain	○	○
Shortness of breath	○	○
irregular heart beat	○	○
shortness of breath when lying down	○	○
palpitations	○	○
Leg edema	○	○
Fainting or near fainting	○	○

Constitutional

None	Y	N
Fatigue or tiredness	○	○
fever	○	○
loss of appetite	○	○
General discomfort	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

ENMT

None	Y	N
dizziness	○	○
double vision	○	○
ear pain	○	○
loss of vision	○	○
nasal obstruction	○	○
nose bleeds	○	○
photophobia	○	○
sore throat	○	○

Endocrine

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

Gastrointestinal

None	Y	N
abdominal pain	○	○
abdominal swelling and/or bloating	○	○
change in bowel habits	○	○
stomach cramps	○	○
constipation	○	○
diarrhea	○	○
Difficulty swallowing	○	○
gas	○	○
heartburn	○	○
yellowing of skin	○	○
nausea	○	○
rectal bleeding	○	○
Rectal Discomfort	○	○
vomiting	○	○
Vomiting blood	○	○

Genitourinary

None	Y	N
dark urine	○	○
decrease in urine flow	○	○
pain on urination	○	○
frequent urinary infections	○	○
frequent urination	○	○
Blood in Urine	○	○
impotence	○	○
excessive night time urination	○	○
urethral discharge or incontinence	○	○

Hematologic/Lymphatic

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

Skin

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

Musculoskeletal

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

Neurological

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

Psychiatric

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

Respiratory

None	Y	N
asthma	○	○
cough	○	○
shortness of breath	○	○
excessive sputum	○	○
Coughing Blood	○	○
shortness of breath with exercise	○	○
wheezing	○	○

Current Medications

☐ None

Name	Dose	How taken?

Pharmacy

Name	Address	Phone

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