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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.

- | | | |
|-----------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> White | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> Patient declines to specify |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other Race | <input type="checkbox"/> Prohibited by state law |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Unknown | |
| <input type="checkbox"/> American Indian or Alaska Native | | |

Ethnicity

- | | | | | |
|---------------------------------------------|-------------------------------------------------|------------------------------------------------------|--------------------------------------------------|----------------------------------|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Patient declines to specify | <input type="checkbox"/> Prohibited by state law | <input type="checkbox"/> Unknown |
|---------------------------------------------|-------------------------------------------------|------------------------------------------------------|--------------------------------------------------|----------------------------------|

Sex

- | | | |
|-------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Other |
|-------------------------------|---------------------------------|--------------------------------|

Preferred Language

- | | | |
|----------------------------------|---------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish; Castilian | <input type="checkbox"/> Patient declines to specify |
|----------------------------------|---------------------------------------------|------------------------------------------------------|

Contact Preference

- | | | | |
|---------------------------------|--------------------------------|------------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Letter | <input type="checkbox"/> Email | <input type="checkbox"/> Patient declines to specify | <input type="checkbox"/> Other: _____ |
|---------------------------------|--------------------------------|------------------------------------------------------|---------------------------------------|

Pharmacy

Name

Address

Phone

Over

Allergies

- Patient has no known allergies
- Adhesive Tape
- Codeine Sulfate
- Erythromycin
- Penicillins
- Patient has no known drug allergies
- 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. (Lung)
- Asthma
- Sleep Apnea
- Blood Clots (Leg)
- Wheezing
- 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)
- Gout
- Fibrositis/Fibromyalgia
- 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
<input type="checkbox"/> Cigarettes	_____	_____	_____	_____
<input type="checkbox"/> Cigar	_____	_____	_____	_____
<input type="checkbox"/> Chewing Tobacco	_____	_____	_____	_____

Drug Use

- None

Type	Quantity	Number	Frequency
<input type="checkbox"/> IV or intranasal drugs	_____	_____	Times/month
<input type="checkbox"/> Recreational	_____	_____	Times/month
<input type="checkbox"/> Marijuana	_____	_____	Times/month
<input type="checkbox"/> Heroin	_____	_____	Times/month
<input type="checkbox"/> Meth	_____	_____	Times/month

Exercise

- None
- Regular exercise
- Occasional exercise

Family Medical History

No knowledge of family history

No family history of

Celiac Sprue

Colon Polyps

Liver Disease

Ulcerative Colitis/

Colon Cancer

Crohn's Disease

Stomach Cancer

IBD

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Review Of Systems

Allergic/Immunologic

None

HIV exposure

Persistent infections

Strong allergic reactions or urticaria

Cardiovascular

None

Chest pain

Dyspnea with exercise

Irregular heart beat

Orthopnea

Palpitations

Peripheral edema

Syncope

Constitutional

None

Fatigue

Fever

Loss of appetite

Malaise

Sweats

Weight gain

Weight loss

ENMT

None

Difficulty swallowing

Dizziness

Ear pain

Nasal obstruction

Nose bleeds

Sore throat

Hearing loss

Endocrine

None

Excessive thirst

Hair loss

Heat intolerance

Eyes

None

Double vision

Loss of vision

Photophobia

Gastrointestinal

None

Abdominal pain

Abdominal swelling

Change in bowel habits

Constipation

Diarrhea

Gas

Heartburn

Jaundice

Nausea

Rectal bleeding

Stomach cramps

Vomiting

Difficulty swallowing

Genitourinary

None

Dark urine

Decrease in urine flow

Dysuria

Frequent urinary infections

Frequent urination

Hematuria

Impotence

Nocturia

Urethral discharge or incontinence

Y N

Y N

Y N

Y N

Y N

Y N

Y N

Y N

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



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