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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.

☐ 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

**Preferred Language**

☐ English ☐ Spanish; Castilian ☐ Patient declines to specify

**Contact Preference**

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

## Pharmacy

| Name | Address | Phone |
|---|---|---|

*Over*

## Allergies

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

☐ Adhesive Tape ☐ Erythromycin ☐ Shellfish ☐ Latex Gloves

☐ Codeine Sulfate ☐ Penicillins ☐ IV Dye, Iodine Containing

## Current Medications

☐ None

| Name | Dose | How taken? |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Immunizations

☐ None

| ☐ Flu vaccine | ☐ Hep A | ☐ Hep B | ☐ Pneumovax | ☐ TB skin test |
| --- | --- | --- | --- | --- |
| When:__________ | When:__________ | When:__________ | When:__________ | When:__________ |

## Diagnostic Studies/Tests

☐ None

| ☐ Colonoscopy | ☐ EGD | ☐ CT Abdomen/Pelvis | ☐ MRI Abdomen/Pelvis | ☐ ERCP |
| --- | --- | --- | --- | --- |
| When:__________ | When:__________ | When:__________ | When:__________ | 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: __________

**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 |
|---|---|---|---|---|
| ☐ Cigarettes | | | | |
| ☐ Cigar | | | | |
| ☐ Chewing Tobacco | | | | |

**Drug Use**
- ☐ None

| Type | Quantity | Number | Frequency |
|---|---|---|---|
| ☐ IV or intranasal drugs | | | Times/month |
| ☐ Recreational | | | Times/month |
| ☐ Marijuana | | | Times/month |
| ☐ Heroin | | | Times/month |
| ☐ 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/IBD ☐ Colon Cancer ☐ Crohn's Disease ☐ Stomach Cancer

| **Diagnoses** | Mother | Father | Sister | Brother | Grandmother | Grandfather |
|---|---|---|---|---|---|---|
| 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 | ☐ | ☐ |
| Persistent infections | ☐ | ☐ |
| Strong allergic reactions or urticaria | ☐ | ☐ |

**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

gciav.com

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