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Patient Interview Form

Patient Information

First Name: _____ Last Name: _____
MRN: _____ Date Of Birth: _____
Age: _____ Notes: _____

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
 Middle Eastern or North African (MENA) 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 Unknown

Preferred Language

English Patient declines to specify

Contact Preference

Letter Email Patient declines to specify Other: _____

Pharmacy

Name _____ Address _____ Phone _____

Allergies

- Patient has no known allergies
 Patient has no known drug allergies
- Adhesive Tape
 Codeine Sulfate
 Erythromycin
 Penicillins
 Shellfish
- Iv Dye, Iodine Containing
 Latex gloves

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: _____
- Cologuard
- When: _____

Previous Procedures

None

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Gallbladder removed | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Colon resection | <input type="checkbox"/> Small Bowel Resection | <input type="checkbox"/> Exploratory Laparoscopy |
| <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Gastric Lap Band | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Hemorrhoid banding | <input type="checkbox"/> Abdominoplasty |
| <input type="checkbox"/> Hysterectomy - Abdominal | <input type="checkbox"/> Bilateral Tubal Ligation (BTL) | <input type="checkbox"/> Mastectomy R Breast | <input type="checkbox"/> Pacemaker Insertion | <input type="checkbox"/> Defibrillator Placement |
| <input type="checkbox"/> Coronary Artery Bypass Graft (CABG) | <input type="checkbox"/> Abdominal aortic aneurysm (AAA) repair | <input type="checkbox"/> Heart valve replacement | <input type="checkbox"/> Cardiac Cath - with stent placement | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Fibromyalgia | Other: _____ | Other: _____ | |

Past or Present Medical Conditions

None

- Gastroenterology/Hepatology**
- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Colon polyp history | <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Gastroesophageal Reflux Disease (GERD) | <input type="checkbox"/> Barrett's Esophagus |
| <input type="checkbox"/> Ulcer Disease | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Fatty Liver |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Bowel Obstruction | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Anemia | Other: _____ | Other: _____ | |

- Cardiology**
- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |

- Transient Ischemic Attack
- Valvular heart disease
- Pacemaker
- Coronary Artery Stents

Other: _____ Other: _____

Pulmonology

- C.O.P.D.
- Asthma
- Sleep apnea
- Blood Clots (leg)
- Blood Clots (lung)
- 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)
- Fibrositis / Fibromyalgia
- Gout
- 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="radio"/> Cigarettes	_____	_____	_____	_____
<input type="radio"/> Cigar	_____	_____	_____	_____
<input type="radio"/> Chewing Tobacco	_____	_____	_____	_____
<input type="radio"/> Vaping	_____	_____	_____	_____
<input type="radio"/> Electronic Cigarette	_____	_____	_____	_____

Drug Use

- None

Type	Quantity	Number	Frequency
<input type="radio"/> IV or intranasal drugs	_____	_____	Times / month
<input type="radio"/> Recreational	_____	_____	Times / month

Exercise

- None

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

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