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# Patient Interview Form

## Patient Information

First Name:_____ Last Name:_____

MRN:_____ Date Of Birth:_____

Age:_____ Notes:_____

### Email

Personal:_____

### 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

- ◯ Arabic
- ◯ Chinese
- ◯ English
- ◯ French
- ◯ German
- ◯ Korean
- ◯ Spanish; Castilian
- ◯ Tagalog
- ◯ Vietnamese
- ◯ Patient declines to specify

### Contact Preference

- ◯ Email
- ◯ Cell phone
- ◯ Telephone call-Work
- ◯ Telephone call - Home
- ◯ Patient declines to specify

## Allergies

- ◯ Patient has no known allergies
- ◯ Patient has no known drug allergies

**General Allergies**

- ◯ Dairy Products — Other:_____
- ◯ Latex — Other:_____
- ◯ Peanuts — Other:_____
- ◯ Shellfish — Other:_____

**Medication Allergies**

- ◯ Penicillins
- ◯ Sulfa
- ◯ Codeine
- ◯ Iodine
- ◯ Demerol
- ◯ Aspirin
- ◯ Fentanyl
- ◯ Versed

Other: Other: Other: Other:

## 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

## Immunizations

☐ None

| ☐ Influenza | ☐ Pneumovax | ☐ Prevnar | ☐ Hepatitis A | ☐ Hepatitis B |
|---|---|---|---|---|
| When: | When: | When: | When: | When: |

## Past or Present Medical Conditions

☐ None

| | | | | |
|---|---|---|---|---|
| **GI** | ☐ Acid Reflux | ☐ Barrett's Esophagus | ☐ Liver enzymes abnormal | ☐ Cirrhosis |
| | ☐ Fatty Liver | ☐ Hepatitis A | ☐ Hepatitis B | ☐ Hepatitis C |
| | ☐ Colon Cancer | ☐ Colon Polyps | ☐ Crohn's Disease | ☐ Diverticulosis |
| | ☐ Diverticulitis | ☐ Gallstones | ☐ Hemorrhoids | ☐ Esophageal Stricture |
| | ☐ H. Pylori Infection | ☐ Irritable Bowel Syndrome | ☐ Pancreatitis | ☐ Gastric Ulcer |
| | ☐ Ulcerative Colitis | ☐ Hiatal hernia | ☐ Liver Disease | ☐ Intestinal obstruction |
| **Cardiac** | ☐ Atrial Fibrillation | ☐ Congestive Heart Failure | ☐ Coronary Artery Disease | ☐ Heart Attack |
| | ☐ High blood pressure | ☐ High Cholesterol | ☐ TIA | ☐ Cerebrovascular Accident (Stroke) |
| **Other** | ☐ Alcohol abuse | ☐ Anemia | ☐ Anxiety Disorder | ☐ Depression |
| | ☐ Arthritis | ☐ Asthma | ☐ Blood Clot in Lung | ☐ Blood Transfusion |

- [ ] Cancer
- [ ] Chronic Lung Disease
- [ ] Diabetes Type 1
- [ ] Diabetes Type 2
- [ ] Drug dependence
- [ ] Endometriosis
- [ ] HIV infection
- [ ] Chronic Kidney Disease
- [ ] Kidney stones
- [ ] Lupus Erythematosus
- [ ] Autoimmune Disease
- [ ] Ovarian Cyst
- [ ] Mental disorder
- [ ] Dementia
- [ ] Seizures
- [ ] Sickle Cell Trait
- [ ] Sleep apnea
- [ ] Disorder of thyroid gland
- [ ] Tuberculosis

## Review Of Systems

**Allergic/Immunologic**

| None | Y | N |
|---|---|---|
| HIV exposure | ○ | ○ |
| persistent infections | ○ | ○ |
| strong allergic reactions or urticaria | ○ | ○ |

**Cardiovascular**

| None | Y | N |
|---|---|---|
| chest pain | ○ | ○ |
| shortness of breath with exercise | ○ | ○ |
| palpitations | ○ | ○ |
| peripheral edema | ○ | ○ |
| syncope | ○ | ○ |

**Constitutional**

| None | Y | N |
|---|---|---|
| fatigue | ○ | ○ |
| fever | ○ | ○ |
| loss of appetite | ○ | ○ |
| weight gain | ○ | ○ |
| weight loss | ○ | ○ |
| recent travel outside of the U.S. | ○ | ○ |

**ENMT**

| None | Y | N |
|---|---|---|
| difficulty swallowing | ○ | ○ |
| nose bleeds | ○ | ○ |
| sore throat | ○ | ○ |
| hoarse voice | ○ | ○ |
| choking | ○ | ○ |

**Endocrine**

| None | Y | N |
|---|---|---|
| excessive thirst | ○ | ○ |
| hair loss | ○ | ○ |

**Eyes**

| None | Y | N |
|---|---|---|
| loss of vision | ○ | ○ |
| recent change in eyesight | ○ | ○ |

**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 | ○ | ○ |
| mucus in stools | ○ | ○ |
| black tarry stools | ○ | ○ |
| small or narrow stools | ○ | ○ |

**Genitourinary**

| None | Y | N |
|---|---|---|
| difficulty with urination | ○ | ○ |
| frequent urinary infections | ○ | ○ |
| blood in urine | ○ | ○ |

**Hematologic/Lymphatic**

| None | Y | N |
|---|---|---|
| easy bruising | ○ | ○ |
| prolonged bleeding | ○ | ○ |
| palpable lymph nodes | ○ | ○ |

**Integumentary**

| None | Y | N |
|---|---|---|
| hives | ○ | ○ |
| itching | ○ | ○ |
| jaundice | ○ | ○ |
| rashes | ○ | ○ |

**Musculoskeletal**

| None | Y | N |
|---|---|---|
| back pain | ○ | ○ |
| joint pain | ○ | ○ |
| muscle weakness | ○ | ○ |

**Neurological**

| None | Y | N |
|---|---|---|
| dizziness | ○ | ○ |
| fainting | ○ | ○ |
| frequent headaches | ○ | ○ |
| migraine | ○ | ○ |
| seizures | ○ | ○ |
| memory loss | ○ | ○ |

**Psychiatric**

| None | Y | N |
|---|---|---|
| anxiety | ○ | ○ |
| depression | ○ | ○ |
| panic attacks | ○ | ○ |

**Respiratory**

| None | Y | N |
|---|---|---|
| cough | ○ | ○ |
| dyspnea | ○ | ○ |
| excessive sputum | ○ | ○ |
| coughing up blood | ○ | ○ |
| wheezing | ○ | ○ |

## Diagnostic Studies / Tests

○ None

| | | | |
|---|---|---|---|
| ☐ EGD<br>When:_____ | ☐ Colonoscopy<br>When:_____ | ☐ Flexible Sigmoidoscopy<br>When:_____ | ☐ Fecal Test To Detect Blood<br>When:_____ |
| **If You Are Diabetic:** ☐ Hemoglobin A1C<br>When:_____ | ☐ Dilated Eye/Retinal Exam<br>When:_____ | | |

## Previous Procedures

☐ None

| | | | | |
|---|---|---|---|---|
| **GI Surgeries** | ☐ Appendix Removed<br>When:_____ | ☐ Hernia Repair - Abdominal Wall<br>When:_____ | ☐ Hernia Repair - Inguinal<br>When:_____ | ☐ Hiatal Hernia Repair<br>When:_____ |
| | ☐ Colon Surgery<br>When:_____ | ☐ Gallbladder Removed<br>When:_____ | ☐ Exploratory Surgery of Abdomen<br>When:_____ | ☐ Hemorrhoid Surgery<br>When:_____ |
| | ☐ Abdominoplasty (Tummy Tuck)<br>When:_____ | ☐ Surgery for Bowel Obstruction or Adhesions<br>When:_____ | ☐ Weight Loss Surgery<br>When:_____ | ☐ Esophagus Surgery<br>When:_____ |
| | ☐ Stomach Surgery<br>When:_____ | ☐ Liver Biopsy<br>When:_____ | | |
| **Cardiac Surgeries/Procedures** | ☐ Angioplasty<br>When:_____ | ☐ Cardiac Cath - intervention unspecified<br>When:_____ | ☐ Coronary Artery Bypass Graft (CABG)<br>When:_____ | ☐ Defibrillator Placement<br>When:_____ |
| | ☐ Pacemaker Insertion<br>When:_____ | ☐ Cardiac Cath - with stent placement<br>When:_____ | ☐ Valve Replacement - Aortic<br>When:_____ | ☐ Valve Replacement - Mitral<br>When:_____ |
| **Other** | ☐ Organ Transplant<br>When:_____ | ☐ Cataract Surgery<br>When:_____ | ☐ Caeserean Section<br>When:_____ | ☐ Hysterectomy<br>When:_____ |
| | ☐ Tubal Ligation<br>When:_____ | | | |

## Family Medical History

☐ No knowledge of family history

| | | |
|---|---|---|
| **No family history of** | ☐ Celiac sprue | ☐ Colon cancer |
| | ☐ Colon polyps | ☐ Crohn's disease |
| | ☐ Liver disease | ☐ Stomach cancer |
| | ☐ Ulcerative Colitis / IBD | |

| **Diagnoses** | Mother | Father | Sister | Brother | Daughter | Son |
|---|---|---|---|---|---|---|
| Colon Cancer | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon Polyps | ○ | ○ | ○ | ○ | ○ | ○ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Liver Disease | ○ | ○ | ○ | ○ | ○ | ○ |
| Esophageal Cancer | ○ | ○ | ○ | ○ | ○ | ○ |
| Stomach Cancer | ○ | ○ | ○ | ○ | ○ | ○ |
| Pancreatic Cancer | ○ | ○ | ○ | ○ | ○ | ○ |
| Inflammatory Bowel Disease | ○ | ○ | ○ | ○ | ○ | ○ |
| Celiac Disease | ○ | ○ | ○ | ○ | ○ | ○ |
| Gallstones | ○ | ○ | ○ | ○ | ○ | ○ |

## Social History

Occupation:_____ Number of Children:_____

**Marital Status**

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
☐ Civil Union ☐ Unknown ☐ Other

**Alcohol**

☐ None

| Type | Quantity | Number | Frequency |
|---|---|---|---|
| ☐ Beer | | | |
| ☐ Wine | | | |
| ☐ Liquor | | | |

**Caffeine**

☐ None

☐ Daily ☐ Occasionally ☐ 1-2 Servings Daily ☐ 3-5 Servings Daily ☐ >5 Servings 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 | | | | |
| ☐ Smokeless | | | | |
| ☐ Other | | | | |

**Drug Use**

☐ None

| Type | Quantity | Number | Frequency |
|---|---|---|---|
| ☐ Marijuana | | | |
| ☐ IV Drug Use | | | |
| ☐ Inhaled Drug | | | |
| ☐ Former User | | | |

**Exercise**

☐ None

- [ ] Less than once a week
- [ ] 1-2 times a week
- [ ] 3-6 times a week
- [ ] Everyday

## 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