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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
 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

Sex

Male Female Other

Preferred Language

English Portuguese Spanish; Castilian Patient declines to specify

Contact Preference

No Preference Patient Portal (email) Letter Patient declines to specify Other: _____

Allergies

Patient has no known allergies Patient has no known drug allergies
 Demerol Eggs Penicillins Propofol Versed
 IV Dye, Iodine Containing Sulfa (Sulfonamide Antibiotics) Soy Latex Nuts
 aspirin Other: _____

Past or Present Medical Conditions

- None
- | | | | | |
|--|--|--|---|--|
| <input type="radio"/> Acid Reflux | <input type="radio"/> Anemia | <input type="radio"/> Anxiety/Depression | <input type="radio"/> Arthritis | <input type="radio"/> Asthma |
| <input type="radio"/> Atrial Fibrillation | <input type="radio"/> Barrett's Esophagus | <input type="radio"/> Bleeding Disorder | <input type="radio"/> Breast Cancer | <input type="radio"/> Celiac Sprue |
| <input type="radio"/> Colon Cancer | <input type="radio"/> Crohn's Disease | <input type="radio"/> Diabetes Mellitus | <input type="radio"/> Diverticulitis | <input type="radio"/> Diverticulosis |
| <input type="radio"/> Emphysema/COPD | <input type="radio"/> Esophageal Cancer | <input type="radio"/> Gallstones | <input type="radio"/> Glaucoma | <input type="radio"/> Gout |
| <input type="radio"/> Gynecological Cancer | <input type="radio"/> Heart Disease | <input type="radio"/> Hepatitis | <input type="radio"/> High blood pressure | <input type="radio"/> High Cholesterol |
| <input type="radio"/> Irritable Bowel Syndrome | <input type="radio"/> Kidney Disease | <input type="radio"/> Kidney Stones | <input type="radio"/> Liver Disease | <input type="radio"/> Lung Cancer |
| <input type="radio"/> Lupus | <input type="radio"/> Osteoporosis | <input type="radio"/> Pancreatitis | <input type="radio"/> Prostate Cancer | <input type="radio"/> Prostate Enlargement |
| <input type="radio"/> Psychiatric Disease | <input type="radio"/> Rheumatoid Arthritis | <input type="radio"/> Seizure disorder | <input type="radio"/> Sleep apnea | <input type="radio"/> Stroke |
| <input type="radio"/> Underactive Thyroid | <input type="radio"/> Ulcer | <input type="radio"/> Ulcerative Colitis | <input type="radio"/> HIV | Other: _____ |

Other: _____

Previous Procedures

- None
- | | | | | |
|--|---|--|---|---|
| <input type="radio"/> Appendectomy | <input type="radio"/> Blood transfusions | <input type="radio"/> Caeserean Section | <input type="radio"/> Cataract Surgery | <input type="radio"/> Colon Surgery |
| <input type="radio"/> Colonoscopy | <input type="radio"/> Colostomy | <input type="radio"/> Defibrillator Placement (AICD) | <input type="radio"/> ERCP | <input type="radio"/> Gallbladder Surgery |
| <input type="radio"/> Gastric Bypass/Obesity Surgery | <input type="radio"/> Gynecologic Surgery | <input type="radio"/> Heart Stent | <input type="radio"/> Heart Surgery | <input type="radio"/> Hernia Repair |
| <input type="radio"/> Hiatal Hernia Repair | <input type="radio"/> Joint Replacement | <input type="radio"/> Orthopedic Surgery | <input type="radio"/> Pacemaker Insertion | <input type="radio"/> Prostate Surgery |
| <input type="radio"/> Tonsillectomy | <input type="radio"/> Upper Endoscopy | Other: _____ | Other: _____ | |

Social History

Occupation: _____

Marital Status

- | | | | | |
|-----------------------------------|-------------------------------|--------------------------------|---------------------------------|-------------------------------|
| <input type="radio"/> Single | <input type="radio"/> Married | <input type="radio"/> Divorced | <input type="radio"/> Separated | <input type="radio"/> Widowed |
| <input type="radio"/> Civil Union | <input type="radio"/> Unknown | <input type="radio"/> Other | | |

Alcohol

- | | | | | |
|------------------------------|-----------------------------|---|---|--|
| <input type="radio"/> None | | | | |
| <input type="radio"/> Rarely | <input type="radio"/> Daily | <input type="radio"/> More than 2 days per week | <input type="radio"/> Less than 2 days per week | <input type="radio"/> I quit using alcohol |

Tobacco

Smoking Status

- | | | | |
|--|---|--|--|
| <input type="radio"/> Current every day smoker | <input type="radio"/> Current some day smoker | <input type="radio"/> Former smoker | <input type="radio"/> Never smoker |
| <input type="radio"/> Smoker, current status unknown | <input type="radio"/> Light tobacco smoker | <input type="radio"/> Heavy tobacco smoker | <input type="radio"/> Unknown if ever smoked |

Drug Use

- None

Review Of Systems

Gastrointestinal		Integumentary		Endocrine	
<input type="radio"/> None	Y N	<input type="radio"/> None	Y N	<input type="radio"/> None	Y N
abdominal pain	<input type="radio"/> <input type="radio"/>	itching	<input type="radio"/> <input type="radio"/>	excessive thirst	<input type="radio"/> <input type="radio"/>
abdominal swelling	<input type="radio"/> <input type="radio"/>	Rash	<input type="radio"/> <input type="radio"/>	Cold intolerance	<input type="radio"/> <input type="radio"/>
Belching	<input type="radio"/> <input type="radio"/>			heat intolerance	<input type="radio"/> <input type="radio"/>
Black stools	<input type="radio"/> <input type="radio"/>	Neurological		Psychiatric	
Bloating	<input type="radio"/> <input type="radio"/>	<input type="radio"/> None	Y N	<input type="radio"/> None	Y N
Blood in stools	<input type="radio"/> <input type="radio"/>	dizziness	<input type="radio"/> <input type="radio"/>	anxiety	<input type="radio"/> <input type="radio"/>
change in bowel habits	<input type="radio"/> <input type="radio"/>	frequent headaches	<input type="radio"/> <input type="radio"/>	depression	<input type="radio"/> <input type="radio"/>
constipation	<input type="radio"/> <input type="radio"/>	seizures	<input type="radio"/> <input type="radio"/>	difficulty sleeping	<input type="radio"/> <input type="radio"/>
diarrhea	<input type="radio"/> <input type="radio"/>	Stroke or Paralysis	<input type="radio"/> <input type="radio"/>	Memory Loss/Confusion	<input type="radio"/> <input type="radio"/>
difficulty swallowing	<input type="radio"/> <input type="radio"/>	Constitutional		Hematologic/Lymphatic	
gas	<input type="radio"/> <input type="radio"/>	<input type="radio"/> None	Y N	<input type="radio"/> None	Y N
heartburn	<input type="radio"/> <input type="radio"/>	fever	<input type="radio"/> <input type="radio"/>	Enlarged glands	<input type="radio"/> <input type="radio"/>
Incontinence to stool	<input type="radio"/> <input type="radio"/>	Night sweats	<input type="radio"/> <input type="radio"/>	prolonged bleeding	<input type="radio"/> <input type="radio"/>
jaundice	<input type="radio"/> <input type="radio"/>	weight gain	<input type="radio"/> <input type="radio"/>		
Loss of appetite	<input type="radio"/> <input type="radio"/>	weight loss	<input type="radio"/> <input type="radio"/>	Musculoskeletal	
nausea	<input type="radio"/> <input type="radio"/>			<input type="radio"/> None	Y N
vomiting	<input type="radio"/> <input type="radio"/>	Eyes		back pain	<input type="radio"/> <input type="radio"/>
Milk Intolerance	<input type="radio"/> <input type="radio"/>	<input type="radio"/> None	Y N	joint pain	<input type="radio"/> <input type="radio"/>
Painful bowel movement	<input type="radio"/> <input type="radio"/>	Change in vision	<input type="radio"/> <input type="radio"/>	muscle pain	<input type="radio"/> <input type="radio"/>
		Eye pain	<input type="radio"/> <input type="radio"/>		
Genitourinary		Dry eyes	<input type="radio"/> <input type="radio"/>	Allergic/Immunologic	
<input type="radio"/> None	Y N			<input type="radio"/> None	Y N
Blood in urine	<input type="radio"/> <input type="radio"/>	ENMT		Ear Infections	<input type="radio"/> <input type="radio"/>
Dark urine	<input type="radio"/> <input type="radio"/>	<input type="radio"/> None	Y N	Flu	<input type="radio"/> <input type="radio"/>
decrease in urine flow	<input type="radio"/> <input type="radio"/>	Bleeding gums	<input type="radio"/> <input type="radio"/>	Pneumonia	<input type="radio"/> <input type="radio"/>
dysuria	<input type="radio"/> <input type="radio"/>	Mouth Sores	<input type="radio"/> <input type="radio"/>		
frequent urinary infections	<input type="radio"/> <input type="radio"/>	nose bleeds	<input type="radio"/> <input type="radio"/>		
frequent urination	<input type="radio"/> <input type="radio"/>	sore throat	<input type="radio"/> <input type="radio"/>		
Irregular Menstruation	<input type="radio"/> <input type="radio"/>	Dry Mouth	<input type="radio"/> <input type="radio"/>		
Pain with urination	<input type="radio"/> <input type="radio"/>	Hoarseness	<input type="radio"/> <input type="radio"/>		
Sexually transmitted disease	<input type="radio"/> <input type="radio"/>				
		Respiratory			
Cardiovascular		<input type="radio"/> None	Y N		
<input type="radio"/> None	Y N	cough	<input type="radio"/> <input type="radio"/>		
Angina/Chest Pressure with activity	<input type="radio"/> <input type="radio"/>	shortness of breath	<input type="radio"/> <input type="radio"/>		
Ankle swelling	<input type="radio"/> <input type="radio"/>	wheezing	<input type="radio"/> <input type="radio"/>		
Irregular Heart Beat	<input type="radio"/> <input type="radio"/>				

Reviewed with

Patient
 Parent
 Guardian
 Not Present