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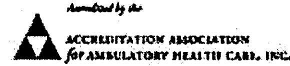

Patient Interview Form

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

Ethnicity

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Patient declines to specify

Sex

- ◯ Male
- ◯ Female
- ◯ Other

Preferred Language

- ◯ English
- ◯ Portuguese
- ◯ Spanish; Castilian
- ◯ Patient declines to specify
- Other:__________

Contact Preference

- ◯ Letter
- ◯ Telephone call
- ◯ Patient Portal (email)
- ◯ 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

Acid Reflux	Anemia	Anxiety/Depression	Arthritis	Asthma
Atrial Fibrillation	Barrett's Esophagus	Bleeding Disorder	Breast Cancer	Celiac Sprue
Colon Cancer	Crohn's Disease	Diabetes Mellitus	Diverticulitis	Diverticulosis
Emphysema/COPD	Esophageal Cancer	Gallstones	Glaucoma	Gout
Gynecological Cancer	Heart Disease	Hepatitis	High blood pressure	High Cholesterol
Irritable Bowel Syndrome	Kidney Disease	Kidney Stones	Liver Disease	Lung Cancer
Lupus	Osteoporosis	Pancreatitis	Prostate Cancer	Prostate Enlargement
Psychiatric Disease	Rheumatoid Arthritis	Seizure disorder	Sleep apnea	Stroke
Underactive Thyroid	Ulcer	Ulcerative Colitis	Other: ______	Other: ______

Previous Procedures

- None

Appendectomy	Blood transfusions	Caeserean Section	Cataract Surgery	Colon Surgery
Colonoscopy	Colostomy	Defibrillator Placement (AICD)	ERCP	Gallbladder Surgery
Gastric Bypass/Obesity Surgery	Gynecologic Surgery	Heart Stent	Heart Surgery	Hernia Repair
Hiatal Hernia Repair	Joint Replacement	Orthopedic Surgery	Pacemaker Insertion	Prostate Surgery
Tonsillectomy	Upper Endoscopy	Other: ______	Other: ______	

Social History

Occupation: ______________________

Marital Status

Single	Married	Divorced	Separated	Widowed
Civil Union	Unknown	Other		

Alcohol

- None

Rarely	Daily	More than 2 days per week	Less than 2 days per week	I quit using alcohol

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

Drug Use

- None

- [ ] I currently use recreational drugs
- [ ] I have used recreational drugs in the past
- [ ] I have been treated for substance abuse
- [ ] I have used IV drugs in the past

Family Medical History

- [ ] No knowledge of family history

No family history of
- [ ] Celiac sprue
- [ ] Colon polyps
- [ ] Colon cancer
- [ ] Ulcerative colitis/Crohn's

Health Status	Mother	Father	Daughter	Son	Brother	Sister	Other
	O	O	O	O	O	O	O
Deceased/At Age	___	___	___	___	___	___	___
Diagnoses							
Colon cancer	O	O	O	O	O	O	O
Colon polyps	O	O	O	O	O	O	O
Breast Cancer	O	O	O	O	O	O	O
Crohn's Disease	O	O	O	O	O	O	O
Ulcerative Colitis	O	O	O	O	O	O	O
Cancer of Esophagus, Stomach, or Pancreas	O	O	O	O	O	O	O
Diabetes mellitus	O	O	O	O	O	O	O
Liver Disease	O	O	O	O	O	O	O
Celiac Disease	O	O	O	O	O	O	O

Pharmacy

Name	Address	Phone

Current Medications

- [ ] None

Name	Dose	How taken?

Review Of Systems

Gastrointestinal ( ) None

	Yes	No
abdominal pain	○	○
abdominal swelling	○	○
Belching	○	○
Black stools	○	○
Bloating	○	○
Blood in stools	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
difficulty swallowing	○	○
gas	○	○
heartburn	○	○
Incontinence to stool	○	○
jaundice	○	○
Loss of appetite	○	○
nausea	○	○
vomiting	○	○
Milk Intolerance	○	○
Painful bowel movement	○	○

Genitourinary ( ) None

	Yes	No
Blood in urine	○	○
Dark urine	○	○
decrease in urine flow	○	○
dysuria	○	○
frequent urinary infections	○	○
frequent urination	○	○
Irregular Menstruation	○	○
Pain with urination	○	○
Sexually transmitted disease	○	○

Cardiovascular ( ) None

	Yes	No
Angina/Chest Pressure with activity	○	○
Ankle swelling	○	○
Irregular Heart Beat	○	○

Integumentary ( ) None

	Yes	No
itching	○	○
Rash	○	○

Neurological ( ) None

	Yes	No
dizziness	○	○
frequent headaches	○	○
seizures	○	○
Stroke or Paralysis	○	○

Constitutional ( ) None

	Yes	No
fever	○	○
Night sweats	○	○
weight gain	○	○
weight loss	○	○

Eyes ( ) None

	Yes	No
Change in vision	○	○
Eye pain	○	○
Dry eyes	○	○

ENMT ( ) None

	Yes	No
Bleeding gums	○	○
Mouth Sores	○	○
nose bleeds	○	○
sore throat	○	○
Dry Mouth	○	○
Hoarseness	○	○

Respiratory ( ) None

	Yes	No
cough	○	○
shortness of breath	○	○
wheezing	○	○

Endocrine ( ) None

	Yes	No
excessive thirst	○	○
Cold intolerance	○	○
heat intolerance	○	○

Psychiatric ( ) None

	Yes	No
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
Memory Loss/Confusion	○	○

Hematologic/Lymphatic ( ) None

	Yes	No
Enlarged glands	○	○
prolonged bleeding	○	○

Musculoskeletal ( ) None

	Yes	No
back pain	○	○
joint pain	○	○
muscle pain	○	○

Allergic/Immunologic ( ) None

	Yes	No
Ear Infections	○	○
Flu	○	○
Pneumonia	○	○

Reviewed with

( ) Patient ( ) Parent ( ) Guardian ( ) Not Present