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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

☐ 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

☐ Chinese ☐ English ☐ Patient declines to specify

Contact Preference

☐ Letter ☐ Email ☐ Cell phone ☐ Telephone call-Work ☐ Telephone call - Home

☐ Patient declines to specify Other:_____

Pharmacy

Name Address Phone

Allergies

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

- [ ] Latex
- [ ] Eggs
- [ ] Peanuts
- [ ] Penicillins
- [ ] Iv Dye, Iodine Containing
- [ ] Soy
- [ ] Diary

Other: _____

Current Medications

- [ ] None

Name	Dose	How taken?

Immunizations

- [ ] None

- [ ] Flu vaccine — When: _____
- [ ] Hep A — When: _____
- [ ] Hep B — When: _____
- [ ] Pneumovax — When: _____
- [ ] TB skin test — When: _____

Diagnostic Studies/Tests

- [ ] None

- [ ] Colonoscopy — When: _____
- [ ] EGD — When: _____
- [ ] ERCP — When: _____
- [ ] Stool Test — When: _____
- [ ] CT Abdomen/Pelvis — When: _____
- [ ] Abdominal Ultrasound — When: _____
- [ ] Capsule Endoscopy — When: _____
- [ ] MRI Abdomen/Pelvis — When: _____
- [ ] Breath Test (Urease - H.Pylori) — When: _____

Other: _____

Past or Present Medical Conditions

- [ ] None

Gastroenterology/Hepatology

- [ ] Anemia
- [ ] Barrett's Esophagus
- [ ] Bowel Obstruction
- [ ] Crohn's Disease
- [ ] Diverticulitis
- [ ] Esophageal Stricture
- [ ] Fatty Liver
- [ ] Gallbladder Disease
- [ ] GERD
- [ ] H. Pylori
- [ ] Hemorrhoids
- [ ] Hiatal Hernia
- [ ] Inflammatory Bowel Disease
- [ ] Irritable Bowel Syndrome
- [ ] Ulcerative Colitis
- [ ] Gastric Cancer
- [ ] Colon cancer
- [ ] Colon polyp history
- [ ] Liver Cancer
- [ ] Intestinal Metaplasia

Other: _____

Cardiology

- [ ] Atrial Fibrillation
- [ ] Coronary Heart Disease
- [ ] Congestive Heart Failure
- [ ] Coronary Artery Stents
- [ ] Deep Vein Thrombosis
- [ ] Endocarditis
- [ ] High blood pressure
- [ ] Pacemaker
- [ ] Valvular heart disease
- [ ] Myocardial infarction

Other: _____

Pulmonology

- [ ] Asthma
- [ ] Emphysema
- [ ] Sleep apnea

Other

- ☐ Arthritis
- ☐ Body piercings
- ☐ Diabetes
- ☐ HIV
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney disease
- ☐ Seizures
- ☐ Tattoos

Previous Procedures

- ☐ None

- ☐ Appendectomy
- ☐ Cardiac Cath - with stent placement
- ☐ Cholecystectomy
- ☐ Colon resection
- ☐ Coronary Artery Bypass Graft (CABG)
- ☐ Defibrillator Placement
- ☐ Gastric Bypass
- ☐ Gastric Lap Band
- ☐ Hemorrhoid banding
- ☐ Hemorrhoidectomy
- ☐ Hysterectomy
- ☐ Pacemaker Insertion
- ☐ Small Bowel Resection
- ☐ Tubal Ligation
- Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

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

Alcohol

- ☐ None

Type	Quantity	Number	Frequency
☐ Less than 7 per week			
☐ More than 7 per week			

Caffeine

- ☐ None

- ☐ Coffee
- ☐ Tea
- ☐ Soda

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

Exercise

- ☐ None

☐ Regular exercise ☐ Occasional exercise

Family Medical History

☐ No knowledge of family history

No family history of

☐ Cirrhosis ☐ Colon cancer
☐ Liver cancer ☐ Stomach cancer

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather	Daughter	Son
Liver cancer	○	○	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○
Cirrhosis	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○
urticaria	○	○
hay fever	○	○

Cardiovascular

None	Y	N
chest pain	○	○
dyspnea with exercise	○	○
irregular heart beat	○	○
orthopnea	○	○
palpitations	○	○
peripheral edema	○	○
syncope	○	○
dyspnea on exertion	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
malaise	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○
chills	○	○

ENMT

None	Y	N
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
sore throat	○	○
hearing loss	○	○
sleep apnea	○	○
URI	○	○

Endocrine

None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○
cold intolerance	○	○
polydipsia	○	○
polyphagia	○	○
polyuria	○	○
weight change	○	○

Eyes

None	Y	N
double vision	○	○
loss of vision	○	○
photophobia	○	○
blurring	○	○
diplopia	○	○
irritation	○	○
discharge	○	○
eye pain	○	○
glaucoma	○	○
cataracts	○	○

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	○	○
oncomycosis	○	○

Musculoskeletal

None	Y	N
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○
neck pain	○	○
joint swelling	○	○
muscle cramps	○	○

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	○	○
memory loss	○	○
mental disturbance	○	○
suicidal ideation	○	○
insomnia	○	○

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

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