

Patient Interview Form

Patient Information

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

Contact Preference

Cell phone Email address: _____ Other: _____

Race

White/Caucasian Black or African American Asian Hispanic or Latino American Indian or Alaska Native
 Native Hawaiian or Other Pacific Islander Mixed Other Unknown Patient declines to provide information

Ethnicity

Hispanic or Latino Not Hispanic or Latino Patient declines to provide information

Preferred Language

English Spanish Other: _____

Allergies

Patient has no known allergies Patient has no known drug allergies
 Latex Penicillins Soy Eggs Others

Current Medications

None

Name	Dose	How taken?
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Pharmacy

Name: _____

Immunizations

None

Hep B, adult Hep A, adult PPD Flu vaccine
When: _____ When: _____ When: _____ When: _____

Diagnostic Studies/Tests

- None
- Colonoscopy Endoscopy CT Abdomen Abdominal U/S
- When: _____ When: _____ When: _____ When: _____

Past or Present Medical Conditions

None

Heart Disease:

- Heart valve replacement Heart Stent Defibrillator Pacemaker
- When: _____ When: _____ When: _____ When: _____
- Atrial Fibrillation Aortic Stenosis History of a heart attack (MI) Seen by a cardiologist in the last 5 years
- When: _____ When: _____ When: _____ When: _____

Lung Disease:

- C.O.P.D. Asthma Home oxygen use Sleep apnea
- When: _____ When: _____ When: _____ When: _____

Other Medical Conditions:

- Diabetes Mellitus Hypertension Hypercholesterolemia Cirrhosis
- When: _____ When: _____ When: _____ When: _____
- Kidney disease/dialysis Anemia
- When: _____ When: _____

Procedure Related details:

- Stroke, MI, Seizure within the last 6 months Can climb 1 flight of stairs without SOB Prior complications from anesthesia Active Chest pain
- When: _____ When: _____ When: _____ When: _____
- Plavix Coumadin
- When: _____ When: _____

Previous Procedures

- None
- Gallbladder removed Appendectomy Colon Resection Hysterectomy Exploratory Abdominal Surgery
- When: _____ When: _____ When: _____ When: _____ When: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

- Single Married Divorced Separated Widowed
- Civil Union Unknown Other

Alcohol

None

Type	Quantity	Frequency
_____	_____	_____
_____	_____	_____

Caffeine

None

Intake: _____

Tobacco

Smoking Status

- Current every day smoker Current some day smoker Former smoker Never smoker
- Smoker, current status unknown Unknown if ever smoked

Drug Use

None

Type	Quantity	Frequency
<input type="radio"/> History of drug use		
<input type="radio"/> Recreational drug use now		

Exercise

None

Type	Quantity	Frequency
<input type="radio"/> Cardiovascular (Treadmill/Elliptical/Stairmaster)		
<input type="radio"/> Weightlifting		
<input type="radio"/> Yoga/Pilates		

Family Medical History

No knowledge of family history

- No family history of**
- | | |
|---------------------------------------|--|
| <input type="radio"/> Celiac Sprue | <input type="radio"/> Colon Cancer |
| <input type="radio"/> Crohn's Disease | <input type="radio"/> Ulcerative Colitis |

