Patient Interview Form

Patient Information

First Name: ______________________ Last Name: ______________________ Date of Birth: __________ Today's Date: __________

Email: ____

Reminder Preference

I would like to receive preventive care and follow up care reminders.

◯ Yes ◯ No

Allergies

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

◯ Latex	◯ Penicillins	◯ Demerol	◯ Fentanyl	◯ Versed
◯ Iodine	◯ Propofol	◯ Sulfa	◯ Eggs	◯ Other: ______________

Past or Present Medical Conditions

◯ None

Neurology:	◯ Stroke	◯ Seizures/Epilepsy	◯ Dementia	◯ Parkinson's
Endocrine:	◯ Thyroid disorder	◯ Diabetes	◯ Osteoporosis	◯ Elevated cholesterol
Cardiac:	◯ Heart attack	◯ Atrial fibrilation	◯ Congestive heart failure	◯ High blood pressure
Lungs:	◯ Asthma	◯ COPD	◯ Valley fever	◯ Sleep apnea
Gastrointestinal:	◯ Barrett's esophagus	◯ Colon polyps	◯ Diverticulosis	◯ Pancreatitis
	◯ GERD	◯ Colon cancer	◯ Irritable Bowel Syndrome	◯ Cirrhosis
	◯ Stomach ulcer	◯ Ulcerative colitis	◯ Lactose intolerance	◯ Hepatitis B
	◯ H. pylori	◯ Crohn's disease	◯ Celiac sprue	◯ Hepatitis C
Urinary:	◯ Enlarged prostate	◯ Kidney stones	◯ Prostate cancer	◯ Kidney failure
Rheumatology:	◯ Fibromyalgia	◯ Lupus	◯ Rheumatoid arthritis	
Blood:	◯ Anemia	◯ Leukemia	◯ Lymphoma	◯ Bleeding disorder
Psychiatric:	◯ Anxiety disorder	◯ Depression	◯ Bipolar disorder	◯ Schizophrenia
Circulation:	◯ Deep vein thrombosis	◯ Pulmonary embolus	◯ Peripheral vascular disease	◯ Carotid artery disease
Cancer:	◯ Cancer (type)			

Any conditions not listed:

◯ Other: ____

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Diagnostic Studies/Tests

- ◯ None

◯ Colonoscopy When: __________	◯ Upper endoscopy When: __________	◯ ERCP When: __________	◯ EUS When: __________	◯ Ultrasound When: __________
◯ MRI When: __________	◯ CT scan When: __________	◯ Liver biopsy When: __________	◯ Recent labs When: __________	

Previous Procedures & Surgeries

- ◯ None

◯ Cataract surgery	◯ Tonsillectomy	◯ Thyroid surgery	◯ Heart valve	◯ Pacemaker
◯ Defibrillator	◯ Appendectomy	◯ Gallbladder removed	◯ Abdominal aneurysm	◯ Carotid artery
◯ C-section	◯ Hysterectomy	◯ Tubal ligation	◯ Breast surgery	◯ Prostate surgery
◯ Joint surgery	◯ Bowel surgery	◯ Hemorrhoids	◯ Coronary bypass	◯ Coronary artery stent

◯ Other: ______________________________

Social History

Occupation: ____ Number of Children: ____________________

Marital Status

◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed
◯ Civil Union

Alcohol

	Quantity	Number	Frequency
◯ None			
◯ Beer			
◯ Wine			
◯ Hard Liquor			

Tobacco

Smoking Status

◯ Current, Every Day Smoker ◯ Current, Some Day Smoker ◯ Former Smoker ◯ Never Smoked
◯ Smoker, Status Unknown ◯ Unknown if ever smoked

Drug Use

	Quantity	Number	Frequency
◯ None			
◯ IV Drugs			
◯ Other			

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Family Medical History

No family history of ◯ Colon cancer ◯ Polyps

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Aunt	Uncle
Colon Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Colon Polyps	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Celiac Disease	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Ulcerative Colitis	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Crohn's Disease	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Liver Disease	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

◯ No knowledge of family history

Current Medications

◯ None

Name	Dose	How Taken?

Pharmacy

Name: ____ Phone: ______________________________

Address: ____ City: _____________ Zip: _____________

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

◯ Yes ◯ No

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Review of Systems *(Please Select All Recent Symptoms)*

Cardiovascular	YES	NO
Chest pain	◯	◯
Shortness of breath with exercise	◯	◯
Palpitations	◯	◯
Constitutional		
Loss of appetite	◯	◯
Weight gain	◯	◯
Weight loss	◯	◯
ENMT		
Sore throat	◯	◯
Nose bleeds	◯	◯
Hoarseness	◯	◯
Endocrine		
Excessive thirst	◯	◯
Hair loss	◯	◯
Heat intolerance	◯	◯
Gastrointestinal		
Abdominal pain	◯	◯
Abdominal bloating	◯	◯
Constipation	◯	◯
Diarrhea	◯	◯
Difficulty swallowing	◯	◯
Gas	◯	◯
Heartburn	◯	◯
Nausea	◯	◯
Rectal bleeding	◯	◯
Vomiting	◯	◯

Genitourinary	YES	NO
Dark urine	◯	◯
Painful urination	◯	◯
Blood in urine	◯	◯
Integumentary		
Yellowing of the skin	◯	◯
Rash	◯	◯
Tattoos	◯	◯
Piercings	◯	◯
Musculoskeletal		
Arthritis	◯	◯
Back pain	◯	◯
Neurological		
Dizziness	◯	◯
Frequent headaches	◯	◯
Numbness or tingling	◯	◯

Psychiatric	YES	NO
Anxiety	◯	◯
Depression	◯	◯
Respiratory		
Cough	◯	◯
Coughing up blood	◯	◯
Wheezing	◯	◯

Reviewed with

◯ Patient ◯ Parent ◯ Guardian ◯ Not Present