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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

☐ Other Race ☐ 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 ☐ Unknown

Sex

☐ Male ☐ Female ☐ Other ☐ Unknown

Preferred Language

☐ English ☐ Patient declines to specify

Contact Preference

☐ Letter ☐ Email ☐ Cell phone ☐ Patient declines to specify Other:_____

Pharmacy

_____

Name Address Phone

Allergies

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

☐ Adhesive Tape ☐ Codeine Sulfate ☐ Erythromycin ☐ Penicillins ☐ Shellfish

☐ Iv Dye, Iodine Containing ☐ Latex gloves Other:_____

Current Medications

☐ None

Name	Dose	How taken?

Immunizations

☐ None

☐ Flu vaccine	☐ Hep A	☐ Hep B	☐ Pneumovax	☐ TB skin test
When:_____	When:_____	When:_____	When:_____	When:_____

Diagnostic Studies/Tests

☐ None

☐ Colonoscopy	☐ EGD	☐ CT Abdomen/Pelvis	☐ MRI Abdomen/Pelvis	☐ ERCP
When:_____	When:_____	When:_____	When:_____	When:_____
☐ Abdominal Ultrasound	☐ stool test			
When:_____	When:_____			

Previous Procedures

☐ None

☐ Gallbladder removed	☐ Appendectomy	☐ Colon resection	☐ Small Bowel Resection	☐ Exploratory Laparoscopy
☐ Gastric Bypass	☐ Gastric Lap Band	☐ Hemorrhoidectomy	☐ Hemorrhoid banding	☐ Abdominoplasty
☐ Hysterectomy - Abdominal	☐ Bilateral Tubal Ligation (BTL)	☐ Pacemaker Insertion	☐ Defibrillator Placement	☐ Coronary Artery Bypass Graft (CABG)
☐ Heart valve replacement	☐ Cardiac Cath - with stent placement	☐ Joint Replacement	☐ Back Surgery	☐ Caeserean Section
Other:_____	Other:_____			

Non-Cardiac Implants ☐ Dentures/Partials ☐ Metal Plate/s

Past or Present Medical Conditions

☐ None

Gastroenterology/Hepatology

☐ Colon polyp history	☐ Colon cancer	☐ Irritable Bowel Syndrome
☐ Diverticulitis	☐ Crohn's Disease	☐ Ulcerative Colitis
☐ Gastroesophageal Reflux Disease (GERD)	☐ Barrett's Esophagus	☐ Ulcer Disease
☐ Hepatitis B	☐ Hepatitis C	☐ Fatty Liver

	⬭ Cirrhosis	⬭ Celiac Disease	⬭ Bowel Obstruction	
		⬭ Anemia	⬭ Hiatal hernia	
	⬭ Diverticulosis	⬭ Constipation	⬭ Abdominal pain	
	⬭ Hemorrhoids	⬭ Dysphagia	⬭ Hemorrhage of anus and rectum	
	Other:	Other:		
Cardiology	⬭ Coronary Artery Disease	⬭ Congestive Heart Failure	⬭ Heart Attack	⬭ High blood pressure
	⬭ Atrial Fibrillation	⬭ Vascular Disease	⬭ High Cholesterol	⬭ Stroke
	⬭ Transient Ischemic Attack	⬭ Valvular heart disease	⬭ Pacemaker	⬭ Coronary Artery Stents
	⬭ Heart murmur	⬭ Pacemaker/Defibillator	Other:	
Pulmonology	⬭ C.O.P.D.	⬭ Asthma	⬭ Sleep apnea	⬭ Blood Clots (leg)
	⬭ Blood Clots (lung)	⬭ Wheezing	Other:	
Other	⬭ Fibrositis / Fibromyalgia	⬭ Osteoporosis	⬭ Arthritis	⬭ Hyperthyroidism
	⬭ Hypothyroidism	⬭ Diabetes Mellitus, Insulin Dependent (Type 1)	⬭ Diabetes Mellitus, Non-Insulin Dependent (Type 2)	⬭ Depression
	⬭ Bipolar disorder	⬭ Anxiety disorder	⬭ Body piercings	⬭ Current pregnancy
	⬭ Gout	⬭ HIV exposure	⬭ HIV infection	⬭ Kidney disease
	⬭ Kidney stones	⬭ Seizures	⬭ Tattoos	⬭ Parkinson's disease
	⬭ Alzheimer's Disease	⬭ Prostate Cancer	⬭ Lung cancer	⬭ Skin Cancer
	⬭ Breast cancer	⬭ Ovarian Cancer	⬭ Rheumatoid arthritis	Other:

Social History

Occupation: _____ Number of Children: _____

Marital Status

⬭ Single	⬭ Married	⬭ Divorced	⬭ Separated	⬭ Widowed
⬭ Civil Union	⬭ Unknown	⬭ Other		

Alcohol

⬭ None	
⬭ Occasionally	⬭ Daily

Caffeine

⬭ None	
⬭ Occasionally	⬭ Daily

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

☐ Celiac sprue ☐ Colon cancer
☐ Colon polyps ☐ Crohn's disease
☐ Liver disease ☐ Stomach cancer
☐ Ulcerative Colitis / IBD

Health Status	Mother	Father	Sister	Brother	Grandmother	Grandfather
Age/Date of Birth						
Healthy	○	○	○	○	○	○
Ill	○	○	○	○	○	○
Seriously Ill	○	○	○	○	○	○
Disabled	○	○	○	○	○	○
In Remission	○	○	○	○	○	○
Alive	○	○	○	○	○	○
Deceased/At Age	○	○	○	○	○	○
Cause of Death						

Diagnoses

Celiac Disease	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○

Liver disease	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Consent to Import Medication History

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

⬭ 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