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: ________	○ DEXA scan 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			

Immunizations

○ None

○ Flu Shot When: ________	○ Pneumonia Vaccine When: ________

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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