Patient Interview Form

Date: _____

Patient Information

First Name: _____ Last Name: _____ Date of Birth: _____

Email: _____

Reminder Preference

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

❑ Yes ❑ No

Allergies

❑ No Known Drug Allergies (NKDA)

❑ Latex ❑ Penicillin ❑ Sulfa ❑ Iodine ❑ Statin ❑ Aspirin/NSAID's ❑ Cephalosporins

❑ Antifungals ❑ Opiates ❑ Antiseizure ❑ Contrast ❑ Antiviral ❑ Other _____

Past or Present Medical Conditions

Neurology: ❑ Stroke ❑ Seizures ❑ Dementia ❑ Parkinson's ❑ Alzheimer's ❑ Epilepsy

Endocrine: ❑ Thyroid ❑ Diabetes ❑ Osteoporosis ❑ Elevated Cholesterol

Cardiac: ❑ Heart attack ❑ A-Fib ❑ Congestive Heart Failure ❑ Hypertension/High blood pressure

Lungs: ❑ Asthma ❑ COPD ❑ Sleep Apnea ❑ Emphysema

Gastrointestinal: ❑ Barrett's ❑ Celiac Sprue ❑ Cirrhosis ❑ Colitis ❑ Colectomy ❑ Colon Cancer

❑ Colon Polyps ❑ Colostomy ❑ Constipation ❑ Crohn's Disease ❑ Diverticulosis ❑ Diverticulitis

❑ Eosinophilic Esophagitis (EoE) ❑ GERD ❑ H. pylori ❑ Irritable Bowel Syndrome (IBS)

❑ Hepatitis A ❑ Hepatitis B ❑ Hepatitis C ❑ Lactose Intolerance ❑ Lynch Syndrome

❑ Pancreatitis ❑ Peptic Ulcer Disease

Urinary: ❑ Bladder Cancer ❑ Bladder Incontinence ❑ Chronic Kidney Disease, Stage 1-4

❑ Kidney Failure ❑ Kidney Stones ❑ Prostate Cancer ❑ Prostate Enlargement

Rheumatology: ❑ Autoimmune Disorder ❑ Fibromyalgia ❑ Lupus ❑ Rheumatoid Arthritis

Blood: ❑ Anemia ❑ Leukemia ❑ Bleeding Disorders ❑ Lymphoma ❑ Sickle Cell Disease

Psychiatric: ❑ Anxiety ❑ Depression ❑ Bipolar Disorder ❑ Schizophrenia

Circulation: ❑ Deep Vein Thrombosis ❑ Pulmonary Embolism ❑ Peripheral Vascular Disease (PVD)

❑ Coronary Artery Disease (CAD)

Cancer: _____

Any conditions not listed:

_____

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Patient Interview Form

Diagnostic Procedures & Test

❑ Capsule Endoscopy (date & findings) _____

❑ Colonoscopy (date & findings) _____

❑ CT (date & findings) _____

❑ EGD (date & findings) _____

❑ ERCP (date & findings) _____

❑ EUS (date & findings) _____

❑ Liver Biopsy (date & findings) _____

❑ MRI (date & findings) _____

❑ PET Scan (date & findings) _____

❑ Recent Labs (date & findings) _____

Previous Procedures & Surgeries

❑ None ❑ Appendectomy ❑ Bowel Surgery ❑ Breast Surgery ❑ C-Section ❑ Carotid Artery

❑ Cardiac Stent ❑ Coronary Bypass ❑ Defibrillator ❑ Gallbladder Removed ❑ Heart Valve ❑ Hemorrhoids

❑ Hysterectomy ❑ Joint or Bone Surgery ❑ Pacemaker ❑ Prostate Surgery ❑ Thyroid Surgery ❑ Tonsillectomy

❑ Tubal Ligation ❑ Other: _____

Social History

Occupation:_____ Number of Children: _____

Marital Status:

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Civil Union

Alcohol

❑ None ❑ Former Drinker: How often and how many: _____

Beer ❑ Daily ❑ Weekly ❑ Monthly ❑ How many: _____

Wine ❑ Daily ❑ Weekly ❑ Monthly ❑ How many: _____

Liquor ❑ Daily ❑ Weekly ❑ Monthly ❑ How many: _____

Tobacco:

❑ Current Every Day ❑ Current Some Day ❑ Former Smoker ❑ Never Smoked ❑ Other forms of Tobacco

Drug Use:

❑ None ❑ IV Drugs ❑ Marijuana ❑ Barbiturates ❑ Cocaine ❑ Opiates ❑ Benzodiazepines

❑ Amphetamines ❑ Phencyclidine ❑ Methaqualone ❑ Methadone

Immunizations

❑ None ❑ Flu Shot Date: _____ ❑ Pneumonia Vaccine Date: _____

Family Medical History

NO family history of: ❑ Colon Cancer ❑ Colon Polyps ❑ Gastric Cancers ❑ Esophageal Cancer

❑ Unknown Family History

Diagnosis	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Aunt	Uncle
Colon Cancer	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Colon Polyps	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Celiac Disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Ulcerative colitis	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Crohn's	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Liver Disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

Current Medications

❑ None

Please list current medications by Name, Dose, Formula, Frequency (example: Pantoprazole 40 mg tablet twice a day)

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

9._____ 10._____

11._____ 12._____

13._____ 14._____

15._____ 16._____

17._____ 18._____

19._____ 20._____

Pharmacy

Name:_____ Phone: _____

Address:_____ City: _____ State: _____ Zip: _____

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Review of Systems (Please select all recent symptoms)

General: ❑ Fatigue ❑ Fever ❑ Night Sweats ❑ Weight Gain ❑ Weight Loss

Respiratory: ❑ Cough ❑ Hemoptysis ❑ Shortness of Breath ❑ Elevated Cholesterol

Cardiovascular: ❑ Anticoagulation therapy ❑ Cardiac arrhythmia ❑ Chest Pain ❑ Weakness

Gastrointestinal: ❑ Abdominal pain ❑ Blood in stool ❑ Change in bowel habits ❑ Constipation
❑ Decreased appetite ❑ Diarrhea ❑ Difficulty swallowing ❑ Heartburn
❑ Nausea ❑ Rectal bleeding ❑ Vomiting

Hematology: ❑ Bleeding disorders ❑ Recent transfusion

Genitourinary: ❑ Blood in urine ❑ Frequent urination ❑ Painful urination

Musculoskeletal: ❑ Muscle aches ❑ Weakness

Neurologic: ❑ Dizziness ❑ Tingling/Numbness

Psychiatric: ❑ Anxiety ❑ Difficulty sleeping ❑ Suicidal thoughts

Other symptoms not listed above: _____

_____

_____

_____

_____

_____

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