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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

MRN:_____ Date Of Birth:_____

Age:_____ Notes:_____

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

☐ 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

Sex

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ Patient declines to specify

Contact Preference

☐ Cell phone ☐ home phone ☐ Patient Portal ☐ Patient declines to specify

Allergies

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

☐ Codeine Sulfate ☐ Demerol ☐ Penicillins ☐ Sulfa (Sulfonamide Antibiotics) ☐ morphine (PF)

☐ aspirin ☐ Hydrocodone-Acetaminophen ☐ Latex ☐ Iodine-Iodine Containing Other:_____

Current Medications

None

Name	Dose	How taken?

Previous Procedures

- [ ] None

- [ ] Colon Resection When:_____
- [ ] Colonoscopy When:_____
- [ ] Liver Biopsy When:_____
- [ ] ERCP When:_____
- [ ] EGD/ Upper Endoscopy When:_____
- [ ] Hemorrhoids When:_____
- [ ] Obesity Surgery When:_____
- [ ] Thyroid When:_____
- [ ] Cardiac Surgery When:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

- [ ] Other
- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Civil Union
- [ ] Unknown

Alcohol

- [ ] None

- [ ] Rarely
- [ ] Daily
- [ ] More than 2 days per week
- [ ] Less than 2 days per week
- [ ] I quit using alcohol

Caffeine

- [ ] None

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

Drug Use

- [ ] None

- [ ] Rarely use recreational drugs
- [ ] Daily use of recreational drugs
- [ ] More than 2 days per week use of recreational drug
- [ ] Less than 2 days per week of recreational drug use
- [ ] I quit using recreational drugs

Exercise

- [ ] None

Pharmacy

Name Address Phone

Past or Present Medical Conditions

☐ None

☐ Anemia When:_____	☐ Colon cancer When:_____	☐ Colon polyps When:_____	☐ Colitis When:_____	☐ Diverticulitis When:_____
☐ Diverticulosis When:_____	☐ Duodenal Ulcer When:_____	☐ Hepatitis When:_____	☐ Hepatitis B When:_____	☐ Hepatitis C When:_____
☐ High blood pressure When:_____	☐ Lactose intolerance When:_____	☐ Stomach ulcer When:_____	☐ High Cholesterol When:_____	☐ HIV/AIDS When:_____
☐ Thyroid disorder When:_____	☐ Ulcerative colitis When:_____	☐ GERD When:_____	☐ Acid Reflux When:_____	☐ Diabetes Mellitus When:_____
☐ Crohn's Disease When:_____	☐ Irregular heart beat When:_____	☐ Congestive Heart Failure When:_____	☐ Heart attack When:_____	☐ Cirrhosis When:_____
☐ Gallstones When:_____	☐ New When:_____	Other:_____		

Family Medical History

☐ No knowledge of family history

No family history of ☐ Colon cancer ☐ Polyps

	Mother	Father	Sister	Brother	Son	Daughter	Grandmother	Grandfather
Health Status								
Alive	○	○	○	○	○	○	○	○
Diagnoses								
Colon Cancer	○	○	○	○	○	○	○	○
Rectal Cancer	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○
Pancreas Cancer	○	○	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○	○	○
Kidney Cancer	○	○	○	○	○	○	○	○
Ovarian Cancer	○	○	○	○	○	○	○	○
Endometrial Cancer	○	○	○	○	○	○	○	○
Skin Cancer	○	○	○	○	○	○	○	○
Brain Cancer	○	○	○	○	○	○	○	○

Review Of Systems

Gastrointestinal

None	Y	N
abdominal pain	○	○
abdominal swelling	○	○
anal/rectal pain	○	○
belching	○	○
black stools	○	○
bloating	○	○
change in bowel habits	○	○
dairy intolerance	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
blood in stool	○	○
difficulty swallowing	○	○
hemorrhoids	○	○
pain with bowel movement	○	○
rectal urgency	○	○

Cardiovascular

None	Y	N
chest pain	○	○
ankle swelling	○	○
heart murmur	○	○
shortness of breath when laying flat	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
night sweats	○	○
weight gain	○	○
weight loss	○	○
chills	○	○

ENMT

None	Y	N
nose bleeds	○	○
sore throat	○	○
hoarseness	○	○

Endocrine

None	Y	N
excessive thirst	○	○
hair loss	○	○
cold intolerance	○	○

Hematologic/Lymphatic

None	Y	N
easy bruising	○	○
prolonged bleeding	○	○
swollen glands	○	○

Musculoskeletal

None	Y	N
arthritis	○	○
back pain	○	○
joint pain	○	○
muscle pain	○	○
stiffness	○	○

Neurological

None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
numbness or tingling	○	○
memory disturbance	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
panic attacks	○	○
suicidal thoughts	○	○

Respiratory

None	Y	N
cough	○	○
wheezing	○	○
cough up blood	○	○

Consent to Import Medication History

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

○ Yes ○ No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

○ 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