



## Patient Interview Form

### Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

#### 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

#### Preferred Language

- Arabic
  English
  Hindi
  Korean
  Spanish; Castilian
- Patient declines to specify

### 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

### Pharmacy

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

### Consent to Import Medication History

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

- Yes
  No

### Current Medications

None

Name	Dose	How taken?

**Allergies**

- Patient has no known allergies       Patient has no known drug allergies
- Penicillins       Adhesive Tape       Antibiotics       Eggs       Soy
- Latex gloves       Sulfa (Sulfonamide Antibiotics)       Contrast Iodine       Anesthesia      Other: \_\_\_\_\_

**Past or Present Medical Conditions** None

- |   |  |   |   |   |                                       |
|---|--|---|---|---|---------------------------------------|
| <b>Cancer</b>   | <input type="radio"/> Esophagus                | <input type="radio"/> Ovaries                   | <input type="radio"/> Skin                            | <input type="radio"/> Stomach                               |                                       |
|   | <input type="radio"/> Lungs                    | <input type="radio"/> Colon                     | <input type="radio"/> Rectum                          | <input type="radio"/> Prostate                              |                                       |
|   | <input type="radio"/> Uterus                   | <input type="radio"/> Leukemia                  | <input type="radio"/> Pancreas                        | <input type="radio"/> Breast                                |                                       |
|   | <input type="radio"/> Bladder                  | <input type="radio"/> Mouth/Throat              | <u>Other:</u> _____                                   |   |                                       |
| <b>Diagnosed GI Conditions</b>  | <input type="radio"/> Celiac Disease/Sprue     | <input type="radio"/> Hiatal Hernia             | <input type="radio"/> Anal Fissure                    | <input type="radio"/> Colon Polyps                          |                                       |
|   | <input type="radio"/> Pancreatitis             | <input type="radio"/> Hemorrhoids               | <input type="radio"/> Gastric Ulcer                   | <input type="radio"/> GERD                                  |                                       |
|   | <input type="radio"/> Diverticulosis           | <input type="radio"/> Diverticulitis            | <input type="radio"/> Hepatitis A                     | <input type="radio"/> Hepatitis B                           |                                       |
|   | <input type="radio"/> Hepatitis C              | <input type="radio"/> Hepatic Failure           | <input type="radio"/> Crohn's Disease                 | <input type="radio"/> Alcohol Abuse                         |                                       |
|   | <input type="radio"/> Irritable Bowel Syndrome | <input type="radio"/> Intestinal Obstruction    | <input type="radio"/> Yellow or Jaundiced Color       | <input type="radio"/> Barrett's Esophagus                   |                                       |
|   | <input type="radio"/> Esophageal Stricture     | <input type="radio"/> Chronic Constipation      | <input type="radio"/> Ulcerative Colitis              | <input type="radio"/> Helicobacter Pylori/H. Pylori         |                                       |
|   | <input type="radio"/> Disorder of Gallbladder  | <input type="radio"/> Gastrointestinal Bleeding | <input type="radio"/> Clostridium Difficile Infection | <input type="radio"/> Antibiotic Treatment in Past 3 Months |                                       |
|   | <input type="radio"/> Cirrhosis/Liver Failure  | <u>Other:</u> _____                             |   |   |                                       |
|   | <b>Non-Gastrointestinal Conditions</b>         | <input type="radio"/> Congestive Heart Failure  | <input type="radio"/> Exposure to HIV                 | <input type="radio"/> Asthma                                | <input type="radio"/> Lupus           |
|   |  | <input type="radio"/> Seizure Disorder          | <input type="radio"/> Stroke                          | <input type="radio"/> Multiple Sclerosis                    | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Heart Attack  |  | <input type="radio"/> Heart Disease             | <input type="radio"/> Blood Clots                     | <input type="radio"/> Anemia                                |                                       |
| <input type="radio"/> HIV Positive  |  | <input type="radio"/> Arthritis                 | <input type="radio"/> High Blood Pressure             | <input type="radio"/> Fibromyalgia                          |                                       |
| <input type="radio"/> Kidney Disease                                      |  | <input type="radio"/> C.O.P.D.                  | <input type="radio"/> Abnormal Heartbeat              | <input type="radio"/> Cardiac Arrhythmia                    |                                       |
| <input type="radio"/> Dyslipidemia  |  | <input type="radio"/> Type 1 Diabetes Mellitus  | <input type="radio"/> Type 2 Diabetes Mellitus        | <input type="radio"/> High Cholesterol                      |                                       |
| <input type="radio"/> Unspecified atherosclerosis (hardening of arteries) |  | <u>Other:</u> _____                             |   |   |                                       |

**Diagnostic Studies/Tests** None Colonoscopy

When: \_\_\_\_\_

 Flexible Sigmoidoscopy

When: \_\_\_\_\_

 EGD

When: \_\_\_\_\_

 ERCP

When: \_\_\_\_\_

 EUS

When: \_\_\_\_\_

 CT Abdomen/Pelvis

When: \_\_\_\_\_

 Abdominal Ultrasound

When: \_\_\_\_\_

 MRI Abdomen/Pelvis

When: \_\_\_\_\_

 MRCP

When: \_\_\_\_\_

**Previous Procedures** None Appendectomy Colectomy Gallbladder Removal Transplant - Liver Pacemaker Insertion Hiatal Hernia Repair Coronary Artery Bypass Graft (CABG) Defibrillator Placement Heart Valve Replacement Cesarean Section Shoulder Surgery Hysterectomy - Abdominal Transplant - Renal Back Surgery Craniotomy/Brain Surgery Lysis of Adhesions TURP Knee Surgery Breast Surgery Cataract Surgery Cosmetic Surgery Hip Replacement Hernia Repair - Umbilical Tonsillectomy Cardiac Cath - with stent placement Abdominal aortic aneurysm (AAA) repair Wisdom Teeth Removal (Extraction)

Other: \_\_\_\_\_

**Social History**

Occupation: \_\_\_\_\_ Number of Children: \_\_\_\_\_

**Marital Status** Single Married Divorced Separated Widowed Civil Union Other**Alcohol** None Daily Weekly Socially Previous**Caffeine** None In the Past 1 cup daily 2-3 cups daily More than 5 Occasional**Drug Use** None Marijuana IV Cocaine Previous Drug Use Other**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

## Family Medical History

No knowledge of family history

No family history of

- Celiac sprue
- Colon polyps
- Liver disease
- Ulcerative Colitis / IBD

- Colon cancer
- Crohn's disease
- Stomach cancer

	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
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### Diagnoses

Colorectal Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colon Polyps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritable Bowel Syndrome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ulcerative Colitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crohn's Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Celiac Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hemochromatosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Autoimmune Hepatitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver Failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ulcer Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gallstone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis C	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stomach Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Uterine Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ovarian Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lung Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Leukemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pancreatic Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### Immunizations

None

Flu vaccine

PCV7 (Pneumonia)

## Review Of Systems

<b>Cardiovascular</b> <input type="radio"/> None	Y N	<b>Endocrine</b> <input type="radio"/> None	Y N	<b>Integumentary</b> <input type="radio"/> None	Y N
chest pain	<input type="radio"/> <input type="radio"/>	excessive thirst	<input type="radio"/> <input type="radio"/>	hives	<input type="radio"/> <input type="radio"/>
fainting	<input type="radio"/> <input type="radio"/>	heat intolerance	<input type="radio"/> <input type="radio"/>	itching	<input type="radio"/> <input type="radio"/>
swelling of extremities	<input type="radio"/> <input type="radio"/>			jaundice	<input type="radio"/> <input type="radio"/>
		<b>Eyes</b> <input type="radio"/> None	Y N	rashes	<input type="radio"/> <input type="radio"/>
<b>Respiratory</b> <input type="radio"/> None	Y N	loss of vision	<input type="radio"/> <input type="radio"/>		
cough	<input type="radio"/> <input type="radio"/>	<b>Gastrointestinal</b> <input type="radio"/> None	Y N	<b>Musculoskeletal</b> <input type="radio"/> None	Y N
dyspnea	<input type="radio"/> <input type="radio"/>	abdominal pain	<input type="radio"/> <input type="radio"/>	back pain	<input type="radio"/> <input type="radio"/>
wheezing	<input type="radio"/> <input type="radio"/>	abdominal swelling	<input type="radio"/> <input type="radio"/>	joint pain	<input type="radio"/> <input type="radio"/>
excessive phlegm	<input type="radio"/> <input type="radio"/>	change in bowel habits	<input type="radio"/> <input type="radio"/>	muscle weakness	<input type="radio"/> <input type="radio"/>
coughing up blood	<input type="radio"/> <input type="radio"/>	constipation	<input type="radio"/> <input type="radio"/>	stiffness	<input type="radio"/> <input type="radio"/>
<b>Constitutional</b> <input type="radio"/> None	Y N	diarrhea	<input type="radio"/> <input type="radio"/>	<b>Neurological</b> <input type="radio"/> None	Y N
fatigue	<input type="radio"/> <input type="radio"/>	gas/flatulence	<input type="radio"/> <input type="radio"/>	dizziness	<input type="radio"/> <input type="radio"/>
fever	<input type="radio"/> <input type="radio"/>	heartburn	<input type="radio"/> <input type="radio"/>	fainting	<input type="radio"/> <input type="radio"/>
loss of appetite	<input type="radio"/> <input type="radio"/>	nausea	<input type="radio"/> <input type="radio"/>	frequent headaches	<input type="radio"/> <input type="radio"/>
weight loss	<input type="radio"/> <input type="radio"/>	rectal bleeding	<input type="radio"/> <input type="radio"/>	migraine	<input type="radio"/> <input type="radio"/>
night sweats	<input type="radio"/> <input type="radio"/>	stomach cramps	<input type="radio"/> <input type="radio"/>	numbness or tingling	<input type="radio"/> <input type="radio"/>
		vomiting	<input type="radio"/> <input type="radio"/>	seizures	<input type="radio"/> <input type="radio"/>
<b>ENMT</b> <input type="radio"/> None	Y N	food intolerance	<input type="radio"/> <input type="radio"/>	memory loss	<input type="radio"/> <input type="radio"/>
ear pain	<input type="radio"/> <input type="radio"/>	vomiting blood	<input type="radio"/> <input type="radio"/>	Dementia	<input type="radio"/> <input type="radio"/>
nasal obstruction	<input type="radio"/> <input type="radio"/>	black stool	<input type="radio"/> <input type="radio"/>	<b>Psychiatric</b> <input type="radio"/> None	Y N
nose bleeds	<input type="radio"/> <input type="radio"/>	pain with bowel movement	<input type="radio"/> <input type="radio"/>	anxiety	<input type="radio"/> <input type="radio"/>
sore throat	<input type="radio"/> <input type="radio"/>	incontinence of stool	<input type="radio"/> <input type="radio"/>	depression	<input type="radio"/> <input type="radio"/>
hearing loss	<input type="radio"/> <input type="radio"/>	blood in stool	<input type="radio"/> <input type="radio"/>	hallucinations	<input type="radio"/> <input type="radio"/>
Sleep Apnea	<input type="radio"/> <input type="radio"/>	difficulty swallowing	<input type="radio"/> <input type="radio"/>	nervousness	<input type="radio"/> <input type="radio"/>
Hoarseness	<input type="radio"/> <input type="radio"/>	<b>Genitourinary</b> <input type="radio"/> None	Y N	panic attacks	<input type="radio"/> <input type="radio"/>
		dark urine	<input type="radio"/> <input type="radio"/>	paranoia	<input type="radio"/> <input type="radio"/>
		painful urination	<input type="radio"/> <input type="radio"/>		
		frequent urination	<input type="radio"/> <input type="radio"/>		
		blood in urine	<input type="radio"/> <input type="radio"/>		

### Reviewed with

Patient
  Parent
  Guardian
  Not Present

### Signature

Signature

Date