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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
- ◯ Portuguese
- ◯ Spanish; Castilian
- ◯ Patient declines to specify

Contact Preference

- ◯ No Preference
- ◯ Patient Portal (email)
- ◯ Letter
- ◯ Patient declines to specify
- Other: ____________

Allergies

- ◯ Patient has no known allergies
- ◯ Patient has no known drug allergies
- ◯ Demerol
- ◯ Eggs
- ◯ Penicillins
- ◯ Propofol
- ◯ Versed
- ◯ IV Dye, Iodine Containing
- ◯ Sulfa (Sulfonamide Antibiotics)
- ◯ Soy
- ◯ Latex
- ◯ Nuts
- ◯ aspirin
- Other: ____________

Past or Present Medical Conditions

- None
- Acid Reflux
- Anemia
- Anxiety/Depression
- Arthritis
- Asthma
- Atrial Fibrillation
- Barrett's Esophagus
- Bleeding Disorder
- Breast Cancer
- Celiac Sprue
- Colon Cancer
- Crohn's Disease
- Diabetes Mellitus
- Diverticulitis
- Diverticulosis
- Emphysema/COPD
- Esophageal Cancer
- Gallstones
- Glaucoma
- Gout
- Gynecological Cancer
- Heart Disease
- Hepatitis
- High blood pressure
- High Cholesterol
- Irritable Bowel Syndrome
- Kidney Disease
- Kidney Stones
- Liver Disease
- Lung Cancer
- Lupus
- Osteoporosis
- Pancreatitis
- Prostate Cancer
- Prostate Enlargement
- Psychiatric Disease
- Rheumatoid Arthritis
- Seizure disorder
- Sleep apnea
- Stroke
- Underactive Thyroid
- Ulcer
- Ulcerative Colitis
- HIV
- Other: ____________
- Other: ____________

Previous Procedures

- None
- Appendectomy
- Blood transfusions
- Caeserean Section
- Cataract Surgery
- Colon Surgery
- Colonoscopy
- Colostomy
- Defibrillator Placement (AICD)
- ERCP
- Gallbladder Surgery
- Gastric Bypass/Obesity Surgery
- Gynecologic Surgery
- Heart Stent
- Heart Surgery
- Hernia Repair
- Hiatal Hernia Repair
- Joint Replacement
- Orthopedic Surgery
- Pacemaker Insertion
- Prostate Surgery
- Tonsillectomy
- Upper Endoscopy
- Other: ____________
- Other: ____________

Social History

Occupation: ____________________________

Marital Status

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

Alcohol

- None
- Rarely
- Daily
- More than 2 days per week
- Less than 2 days per week
- I quit using alcohol

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

I currently use recreational drugs

I have used recreational drugs in the past

I have been treated for substance abuse

I have used IV drugs in the past

Family Medical History

No knowledge of family history

No family history of

- Celiac sprue
- Colon polyps
- Colon cancer
- Ulcerative colitis/Crohn's

Health Status	Mother	Father	Daughter	Son	Brother	Sister	Other
Deceased/At Age							
Diagnoses							
Colon cancer							
Colon polyps							
Breast Cancer							
Cancer of Esophagus							
Cancer of Stomach							
Pancreatic Cancer							
Crohn's Disease							
Ulcerative Colitis							
Diabetes mellitus							
Liver Disease							
Celiac Disease							

Pharmacy

Name Address Phone

Current Medications

None

Name	Dose	How taken?

Review Of Systems

Gastrointestinal
None

	Y	N
abdominal pain	◯	◯
abdominal swelling	◯	◯
Belching	◯	◯
Black stools	◯	◯
Bloating	◯	◯
Blood in stools	◯	◯
change in bowel habits	◯	◯
constipation	◯	◯
diarrhea	◯	◯
difficulty swallowing	◯	◯
gas	◯	◯
heartburn	◯	◯
Incontinence to stool	◯	◯
jaundice	◯	◯
Loss of appetite	◯	◯
nausea	◯	◯
vomiting	◯	◯
Milk Intolerance	◯	◯
Painful bowel movement	◯	◯

Genitourinary
None

	Y	N
Blood in urine	◯	◯
Dark urine	◯	◯
decrease in urine flow	◯	◯
dysuria	◯	◯
frequent urinary infections	◯	◯
frequent urination	◯	◯
Irregular Menstruation	◯	◯
Pain with urination	◯	◯
Sexually transmitted disease	◯	◯

Cardiovascular
None

	Y	N
Angina/Chest Pressure with activity	◯	◯
Ankle swelling	◯	◯
Irregular Heart Beat	◯	◯

Integumentary
None

	Y	N
itching	◯	◯
Rash	◯	◯

Neurological
None

	Y	N
dizziness	◯	◯
frequent headaches	◯	◯
seizures	◯	◯
Stroke or Paralysis	◯	◯

Constitutional
None

	Y	N
fever	◯	◯
Night sweats	◯	◯
weight gain	◯	◯
weight loss	◯	◯

Eyes
None

	Y	N
Change in vision	◯	◯
Eye pain	◯	◯
Dry eyes	◯	◯

ENMT
None

	Y	N
Bleeding gums	◯	◯
Mouth Sores	◯	◯
nose bleeds	◯	◯
sore throat	◯	◯
Dry Mouth	◯	◯
Hoarseness	◯	◯

Respiratory
None

	Y	N
cough	◯	◯
shortness of breath	◯	◯
wheezing	◯	◯

Endocrine
None

	Y	N
excessive thirst	◯	◯
Cold intolerance	◯	◯
heat intolerance	◯	◯

Psychiatric
None

	Y	N
anxiety	◯	◯
depression	◯	◯
difficulty sleeping	◯	◯
Memory Loss/Confusion	◯	◯

Hematologic/Lymphatic
None

	Y	N
Enlarged glands	◯	◯
prolonged bleeding	◯	◯

Musculoskeletal
None

	Y	N
back pain	◯	◯
joint pain	◯	◯
muscle pain	◯	◯

Allergic/Immunologic
None

	Y	N
Ear Infections	◯	◯
Flu	◯	◯
Pneumonia	◯	◯

Reviewed with

Patient Parent Guardian Not Present