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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Race

- ☐ White/Caucasian
- ☐ Black or African American
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Mixed
- ☐ Other
- ☐ Unknown
- ☐ Patient declines to provide information

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient declines to provide information

Gender

- ☐ Male
- ☐ Female
- ☐ Other

Preferred Language

- ☐ English
- ☐ Spanish
- Other:_____

Contact Preference

- ☐ Home Phone
- ☐ Cell Phone
- ☐ Work Phone

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Aspirin
- ☐ Codeine Sulfate
- ☐ Dairy Products
- ☐ Iodine
- ☐ Latex
- ☐ Penicillins
- ☐ Sulfa
- ☐ Adhesive Tape
- Other:_____

Current Medications

- [ ] None

Immunizations

- [ ] None
- [ ] Hepatitis A — When:_____
- [ ] Hepatitis B — When:_____
- [ ] HPV — When:_____
- [ ] Meningococcal — When:_____
- [ ] Pneumococcal — When:_____
- [ ] Influenza, seasonal, injectable — When:_____
- [ ] Shingles — When:_____

Diagnostic Studies/Tests

- [ ] None
- [ ] Labs — When:_____
- [ ] Bone Density — When:_____
- [ ] Abdominal U/S — When:_____
- [ ] CT Abdomen — When:_____
- [ ] CT Pelvis — When:_____
- [ ] Barium Swallow — When:_____
- [ ] Small Bowel Series — When:_____
- [ ] Colonoscopy — When:_____
- [ ] EGD — When:_____
- [ ] Capsule Endoscopy — When:_____

Past or Present Medical Conditions

- [ ] None
- [ ] Cirrhosis
- [ ] Colon polyps
- [ ] Crohn's Disease
- [ ] Diverticulitis
- [ ] Gallstones
- [ ] Groin Hernia
- [ ] Hepatitis
- [ ] Irritable Bowel
- [ ] Pancreatitis
- [ ] Stomach ulcer
- [ ] Ulcerative Colitis
- [ ] Diabetes Type I
- [ ] Diabetes Type 2
- [ ] Heart Disease
- [ ] Hiatal hernia
- [ ] Hemorrhoids
- [ ] High blood pressure
- [ ] Hypothyroidism
- [ ] Elevated cholesterol
- [ ] Hyperthyroidism
- [ ] Breast cancer
- [ ] Colon cancer
- [ ] Barrett's Esophagus
- [ ] Esophagitis
- [ ] Celiac sprue
- [ ] GERD
- [ ] Esophageal stricture
- [ ] OTHER not listed_____
- [ ] Diverticulosis

Previous Procedures

- [ ] None
- [ ] Appendectomy
- [ ] Artificial Heart Valve
- [ ] Cardiac (CABG)
- [ ] Cardiac (VALVE)
- [ ] Colon Resection
- [ ] Colostomy
- [ ] C-Section
- [ ] Dialysis
- [ ] ERCP
- [ ] Gallbladder
- [ ] Groin Hernia
- [ ] Heart Stent Placement
- [ ] Hysterectomy
- [ ] Joint Replacement
- [ ] Kidney
- [ ] Liver Biopsy
- [ ] Obesity Surgery
- [ ] Ovary Surgery
- [ ] Pacemaker
- [ ] Prostate Surgery
- [ ] Stomach
- [ ] Thyroid
- [ ] Tubal Ligation
- [ ] Radiation Therapy: body location_____
- [ ] Hemorrhoid surgery
- [ ] Fundoplication
- [ ] Defibrillator
- [ ] OTHER not listed _____

Social History

Occupation:_____ Number of Children:_____

Marital Status

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

Alcohol

☐ None

	Type	Quantity	Number	Frequency
☐	Alcoholic Drink			

Caffeine

☐ None

☐ Coffee ☐ Tea ☐ Chocolate ☐ Energy Drink ☐ soda

Tobacco

Smoking Status

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker
☐ Smoker, current status unknown ☐ Unknown if ever smoked

	Type	Started	Quit	Quantity	Frequency
☐	Cigarettes				Packs / Day

Drug Use

☐ None

	Type	Quantity	Number	Frequency
☐	Recreational Drugs			Times / week

Exercise

☐ None

	Type	Quantity	Number	Frequency
☐	Walking			Times / week
☐	Running			Times / week
☐	Weight Lifting			Times / week

FAMILY MEDICAL HISTORY: PLEASE CHECK THE FOLLOWING AND FILL IN THE TABLE BELOW, USE EXTRA PAPER IF NEEDED

- ☐ **NO KNOWLEDGE OF FAMILY HISTORY**
- ☐ **YES I HAVE A FAMILY HISTORY OF <u>COLON CANCER</u>**
- ☐ **YES I HAVE A FAMILY HISTORY OF <u>COLON POLYPS</u>**

Health Status or history	Mother	Father	Sister (s)	Brother (s)	Daughter (s)	Son (s)	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Age										
Age at time of death										
Cause of death if known										
Diagnosis	Put an X in the box for the known disease or diseases									
Colon Cancer										
Colon Polyps										
Heart Disease										
Celiac Disease										
Colitis										
Crohn's Disease										
Esophageal cancer										
Liver Disease										
Pancreatic Cancer										
Stomach Cancer										
Breast Cancer										
Ovarian Cancer										
Uterine Cancer										

Review of Systems

Allergic / Immunologic

- no symptoms
- HIV exposure

Cardiovascular

- no symptoms
- chest pain
- irregular heartbeat
- difficulty breathing while laying flat
- palpitations . . . (abnormal heartbeat)

Constitutional

- no symptoms
- fever
- loss of appetite
- weight gain
- weight loss

ENMT

- no symptoms
- difficulty swallowing

Gastrointestinal

- no symptoms
- abdominal pain
- abdominal swelling
- change in bowel habits
- constipation
- diarrhea
- gas
- heartburn
- nausea
- rectal bleeding
- rectal leakage
- stomach cramps
- vomiting

Genitourinary

- no symptoms
- dark urine
- pain with urination
- frequent urination
- blood in urine
- nocturia (night-time urination) *cant't hold urine through the night while sleeping

Hematologic / Lymphatic

- no symptoms
- easy bruising

Integumentary

- no symptoms
- jaundice (yellowing of skin)

Musculoskeletal

- no symptoms
- arthritis
- back pain
- joint pain

Neurological

- no symptoms
- dizziness
- migraine
- numbness or tingling
- seizures

Psychiatric

- no symptoms
- anxiety
- depression
- difficulty sleeping
- panic attacks

Respiratory

- no symptoms
- asthma
- cough
- short of breath
- oxygen used at night or continuous
- shortness of breath with exercise
- wheezing

Pharmacy Name: _____

City where pharmacy is located: _____

-over -

MEDICATION LIST: Please list and bring all current medications, prescription and non-prescription in their original bottles to your appointment (including aspirin, natural, herbal vitamins and supplements)

Medication Name	**Dosage**	**How often do you take this medication**
Example: Tylenol	500mg	One twice a day