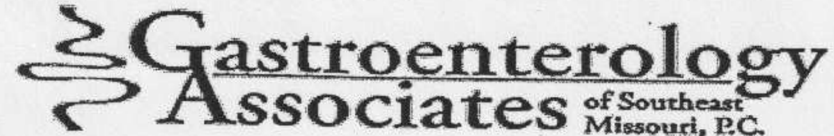

1429 N. Mount Auburn Rd. • Cape Girardeau, MO 63701 • Ph 573-334-8870 • Fax 573-334-7340

Matthew J. Coleman, M.D.   H. L. Schneider, Jr., D.O.   Dean A. Edwards, M.D.   Timothy J. Edwards, M.D.

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
- ○ Unknown
- ○ Patient declines to specify

Ethnicity

- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Patient declines to specify

Sex

- ○ Male
- ○ Female
- ○ Other

Preferred Language

- ○ English
- ○ Patient declines to specify

Contact Preference

- ○ Home Phone
- ○ Cell Phone
- ○ Work Phone
- ○ Patient declines to specify

Allergies

- ○ Patient has no known allergies
- ○ Patient has no known drug allergies

- ○ Aspirin
- ○ Codeine Sulfate
- ○ Dairy Products
- ○ Iodinated Contrast Media - Iv Dye
- ○ latex gloves
- ○ Penicillins
- ○ Sulfa (Sulfonamide Antibiotics)
- ○ Adhesive Tape
- ○ Cyclobenzaprine

Other:______________

Medication List

Please **list and bring** all current medications (prescription and non-prescription).
Bring them 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 pill -- twice a day

Consent to Import Medication History

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

- Yes
- No

Pharmacy

Name ______ Address ______ Phone ______

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	Diverticulosis	Other:______	

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
- ⬭ Light tobacco smoker
- ⬭ Heavy tobacco smoker
- ⬭ 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

- ○ No knowledge of family history

No family history of ○ colon cancer ○ Family Hx of Colon Polyps ○ Family Hx of Colon Cancer

Health Status	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Age/Date of Birth	____	____	____	____	____	____	____	____	____	____
Deceased/At Age	○ ____	○ ____	○ ____	○ ____	○ ____	○ ____	○ ____	○ ____	○ ____	○ ____
Cause of Death	____	____	____	____	____	____	____	____	____	____
Diagnoses										
Colon Cancer	○	○	○	○	○	○	○	○	○	○
Colon Polyp	○	○	○	○	○	○	○	○	○	○
Prostate Cancer	○	○	○	○	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○	○	○	○	○
Colitis	○	○	○	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○	○	○	○
Ovarian Cancer	○	○	○	○	○	○	○	○	○	○
Uterine Cancer	○	○	○	○	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

○ None

	Y	N
HIV exposure	○	○

Cardiovascular

○ None

	Y	N
chest pain	○	○
dyspnea with exercise	○	○
irregular heart beat	○	○
difficulty breathing in bed	○	○
palpitations	○	○

Constitutional

○ None

	Y	N
fever	○	○
loss of appetite	○	○
weight gain	○	○
weight loss	○	○

ENMT

○ None

	Y	N
difficulty swallowing	○	○

Gastrointestinal

○ None

	Y	N
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○

Genitourinary

○ None

	Y	N
dark urine	○	○
pain with urination	○	○
frequent urination	○	○
blood in urine	○	○
nocturia	○	○

Hematologic/Lymphatic

○ None

	Y	N
easy bruising	○	○

Integumentary

○ None

	Y	N
jaundice	○	○

Musculoskeletal

○ None

	Y	N
arthritis	○	○
back pain	○	○
joint pain	○	○

Neurological

○ None

	Y	N
dizziness	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○

Psychiatric

○ None

	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
panic attacks	○	○

Respiratory

○ None

	Y	N
asthma	○	○
cough	○	○
short of breath	○	○
oxygen used at night or continuous	○	○
shortness of breath with exercise	○	○
wheezing	○	○

Reviewed with

○ Patient ○ Parent ○ Guardian ○ Not Present