

Patient Interview Form

Complete all 4 pages, sign and bring to appointment



Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____

Chief Complaint (reason for visit): _____

Allergies and Reaction

Patient has no known drug allergies

Allergy:	Reaction:	Allergy:	Reaction:
<input type="checkbox"/> Latex	_____	<input type="checkbox"/>	_____
<input type="checkbox"/> Iodine-contrast dye	_____	<input type="checkbox"/>	_____
<input type="checkbox"/> Eggs	_____	<input type="checkbox"/>	_____
<input type="checkbox"/> Surgical Tape	_____	<input type="checkbox"/>	_____

Current Medications, including over-the-counter

None

Name	Dose	How Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy

Name: _____

Immunizations

None Hepatitis A Hepatitis B Flu Vaccine
When: _____ When: _____ When: _____

Past or Present Medical Conditions

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> CHF-Congestive heart failure | <input type="checkbox"/> COPD-Chronic obstructive pulmonary disease | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Colon cancer |
| <input type="checkbox"/> CAD-Coronary artery disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Elevated cholesterol | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Colon polyp(s) | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Heart stent | <input type="checkbox"/> Heart valve condition | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Gastric ulcer | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Liver cirrhosis |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Defibrillator (AICD) only | <input type="checkbox"/> Pacemaker only | <input type="checkbox"/> Pacemaker with defibrillator | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Ulcerative colitis | | | | |

Diagnostic Studies/Tests

<input type="radio"/> None	<input type="radio"/> Colonoscopy	<input type="radio"/> Upper Endoscopy	<input type="radio"/> ERCP	<input type="radio"/> Flexible Sigmoidoscopy	<input type="radio"/> Capsule Endoscopy
When: _____	When: _____	When: _____	When: _____	When: _____	When: _____
<input type="radio"/> Endoscopic Ultrasound	<input type="radio"/> Abdominal Ultrasound	<input type="radio"/> Barium Esophogram	<input type="radio"/> CT Abdomen	<input type="radio"/> HIDA Scan	
When: _____	When: _____	When: _____	When: _____	When: _____	When: _____
<input type="radio"/> Liver Biopsy	<input type="radio"/> Stool Studies	<input type="radio"/> Other: _____	<input type="radio"/> Other: _____		
When: _____	When: _____	When: _____	When: _____		

Previous Surgeries/Procedures

<input type="radio"/> None	<input type="radio"/> Bladder Surgery	<input type="radio"/> CABG-Coronary artery bypass graft	<input type="radio"/> Gallbladder removed	<input type="radio"/> Hiatal Hernia repair	<input type="radio"/> Inguinal Hernia repair
When: _____	When: _____	When: _____	When: _____	When: _____	When: _____
<input type="radio"/> Hysterectomy	<input type="radio"/> Colon resection	<input type="radio"/> Other: _____	<input type="radio"/> Other: _____	<input type="radio"/> Other: _____	
When: _____	When: _____	When: _____	When: _____	When: _____	When: _____

Social History

Occupation: _____

Marital Status

<input type="radio"/> Single	<input type="radio"/> Married	<input type="radio"/> Divorced	<input type="radio"/> Separated	<input type="radio"/> Widowed
<input type="radio"/> Civil Union	<input type="radio"/> Other			

Alcohol

None

Type _____ Quantity _____ How Often _____

Caffeine

None

Intake: _____

Tobacco

Smoking Status	<input type="radio"/> Current every day smoker	<input type="radio"/> Current some day smoker	<input type="radio"/> Former smoker	<input type="radio"/> Never smoker
	<input type="radio"/> Smoker, current status unknown	<input type="radio"/> Unknown if ever smoked		

Type _____ Started _____ Quit _____ Quantity _____ How Often _____

Drug Use

None

Type _____ Quantity _____ How Often _____

Review of Systems - In the last 2 Months have you had any of the following: (please answer all questions)

Constitutional	Yes	No	Musculoskeletal	Yes	No
Fatigue	<input type="radio"/>	<input type="radio"/>	Joint pain	<input type="radio"/>	<input type="radio"/>
Fever	<input type="radio"/>	<input type="radio"/>	Back pain	<input type="radio"/>	<input type="radio"/>
Night sweats	<input type="radio"/>	<input type="radio"/>	Muscle aches	<input type="radio"/>	<input type="radio"/>
Weight loss	<input type="radio"/>	<input type="radio"/>			
Weight gain	<input type="radio"/>	<input type="radio"/>	Neurological	Yes	No
			Poor sleep	<input type="radio"/>	<input type="radio"/>
Hematologic/Lymphatic	Yes	No	Dizziness	<input type="radio"/>	<input type="radio"/>
Easy bruising	<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>	Seizures	<input type="radio"/>	<input type="radio"/>
Bleeding	<input type="radio"/>	<input type="radio"/>	Weakness arm, leg	<input type="radio"/>	<input type="radio"/>
			Numbness or tingling	<input type="radio"/>	<input type="radio"/>
Respiratory	Yes	No	Loss of memory	<input type="radio"/>	<input type="radio"/>
Short of breath	<input type="radio"/>	<input type="radio"/>			
Cough	<input type="radio"/>	<input type="radio"/>	Gastrointestinal	Yes	No
			Abdominal pain	<input type="radio"/>	<input type="radio"/>
Integumentary/Skin	Yes	No	Abdominal swelling	<input type="radio"/>	<input type="radio"/>
Rash	<input type="radio"/>	<input type="radio"/>	Change in bowel habits	<input type="radio"/>	<input type="radio"/>
Hives	<input type="radio"/>	<input type="radio"/>	Constipation	<input type="radio"/>	<input type="radio"/>
Itching	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>
			Gas	<input type="radio"/>	<input type="radio"/>
ENMT	Yes	No	Heartburn	<input type="radio"/>	<input type="radio"/>
Hearing problems	<input type="radio"/>	<input type="radio"/>	Jaundice	<input type="radio"/>	<input type="radio"/>
Poor vision	<input type="radio"/>	<input type="radio"/>	Nausea	<input type="radio"/>	<input type="radio"/>
Nasal congestion	<input type="radio"/>	<input type="radio"/>	Rectal bleeding	<input type="radio"/>	<input type="radio"/>
Sore throat	<input type="radio"/>	<input type="radio"/>	Stomach cramps	<input type="radio"/>	<input type="radio"/>
			Vomiting	<input type="radio"/>	<input type="radio"/>
Genitourinary	Yes	No	Black or bright red blood in stool	<input type="radio"/>	<input type="radio"/>
Pain when urinating	<input type="radio"/>	<input type="radio"/>	Difficulty swallowing	<input type="radio"/>	<input type="radio"/>
Difficulty urinating	<input type="radio"/>	<input type="radio"/>			
Blood in urine	<input type="radio"/>	<input type="radio"/>	Psychiatric	Yes	No
			Anxiety	<input type="radio"/>	<input type="radio"/>
Cardiovascular	Yes	No	Depression	<input type="radio"/>	<input type="radio"/>
Chest pain	<input type="radio"/>	<input type="radio"/>	Panic attacks	<input type="radio"/>	<input type="radio"/>
Palpitations	<input type="radio"/>	<input type="radio"/>			
Swollen legs, ankles	<input type="radio"/>	<input type="radio"/>			
Trouble breathing at night	<input type="radio"/>	<input type="radio"/>			
Fainting/blackouts	<input type="radio"/>	<input type="radio"/>			
Leg pain when walking	<input type="radio"/>	<input type="radio"/>			

Family Medical History

No knowledge of family history

Family Health Status	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather
Alive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Deceased/ at age	<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 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"/>
Colon polyp	<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"/>
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"/>
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"/>
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"/>
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"/>

I DO **NOT** have any family history of the following:

- | | |
|--|---|
| <input type="radio"/> colon cancer | <input type="radio"/> colon polyps |
| <input type="radio"/> Crohn's disease | <input type="radio"/> esophageal cancer |
| <input type="radio"/> GI cancer | <input type="radio"/> GYN cancer |
| <input type="radio"/> inflammatory bowel disease | <input type="radio"/> liver disease |
| <input type="radio"/> pancreatic cancer | <input type="radio"/> stomach cancer |
| <input type="radio"/> ulcerative colitis | |

Signature

Signature

Date

MD/PA Initials

Date