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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

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

☐ 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

Sex

☐ Male ☐ Female ☐ Other ☐ Unknown

Preferred Language

☐ English ☐ Patient declines to specify

Contact Preference

☐ Telephone call ☐ Portal Message ☐ Patient declines to specify Other:_____

Immunizations

☐ None

☐ Hep A, adult When:_____ ☐ Hep B, adult When:_____ ☐ PPD When:_____ ☐ Flu Vaccine When:_____ ☐ Pneumonia Vaccine When:_____

☐ COVID Vaccine When:_____ ☐ BCG When:_____ ☐ Shingles Vaccine When:_____ Other:_____

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

⬭ Penicillins	⬭ Latex	⬭ Iodinated Contrast Media	⬭ Demerol	⬭ fentanyl citrate
⬭ Valium	⬭ midazolam	⬭ Propofol	⬭ Sulfa	⬭ Shellfish Containing Products
⬭ Egg Derived	Other: _____			

Pharmacy

Name	Address	Phone

Current Medications

None

Name	Dose	How taken?

Diagnostic Studies/Tests

- [ ] None

- [ ] Upper GI X-Ray When:_____
- [ ] EGD When:_____
- [ ] Small Bowel X-Ray When:_____
- [ ] Sigmoidoscopy When:_____
- [ ] Barium Enema When:_____
- [ ] Colonoscopy When:_____
- [ ] CT Scan When:_____
- [ ] Ultrasound When:_____
- [ ] Liver Biopsy When:_____
- [ ] Capsule Endoscopy When:_____
- [ ] ERCP When:_____
- [ ] EUS When:_____
- [ ] MRCP When:_____

Past or Present Medical Conditions

- [ ] None

Respiratory

- [ ] No Respiratory Issues When:_____
- [ ] Asthma When:_____
- [ ] Bronchitis When:_____
- [ ] Emphysema When:_____
- [ ] C.O.P.D. When:_____
- [ ] Sleep apnea When:_____
- [ ] TB When:_____
- [ ] Upper Respiratory Infection When:_____
- [ ] Home Oxygen When:_____
- [ ] CPAP When:_____
- [ ] BPAP When:_____
- [ ] COVID-19 When:_____

Cardiovascular

- [ ] No Cardio Issues When:_____
- [ ] Congestive Heart Failure When:_____
- [ ] Atrial Fibrilation When:_____
- [ ] Coronary Artery Disease When:_____
- [ ] Angina When:_____
- [ ] Rheumatic Fever When:_____
- [ ] Mitral Valve Prolapse When:_____
- [ ] Myocardial infarction/Heart Attack When:_____
- [ ] Arrhythmia When:_____
- [ ] Heart Murmurs When:_____
- [ ] Pacemaker When:_____
- [ ] Hypertension/High Blood Pressure When:_____
- [ ] Peripheral Vascular Disease When:_____
- [ ] Valvular heart disease When:_____
- [ ] Hypercholesterolemia/High Cholesterol When:_____
- [ ] AICD When:_____
- [ ] Port When:_____
- [ ] Blood thinning medication When:_____

Gastrointestinal

- [ ] No Gastro Issues When:_____
- [ ] Acid Reflux When:_____
- [ ] Esophagitis When:_____
- [ ] Ulcers When:_____
- [ ] Gallbladder Disease When:_____
- [ ] Hepatitis When:_____
- [ ] Liver Disease When:_____
- [ ] Jaundice When:_____
- [ ] Ulcerative Colitis When:_____
- [ ] Crohn's Disease When:_____
- [ ] IBS When:_____
- [ ] Diverticulitis When:_____
- [ ] Hemorrhoids When:_____
- [ ] Colon Cancer When:_____
- [ ] GI Bleeding When:_____
- [ ] Cirrhosis When:_____
- [ ] Hiatal Hernia When:_____
- [ ] GERD When:_____
- [ ] Peptic Ulcer Disease When:_____
- [ ] Mucus in stool When:_____
- [ ] Fecal incontinence with fecal urgency When:_____
- [ ] Vomiting blood - fresh When:_____
- [ ] Adenomatous Polyp When:_____
- [ ] Hyperplastic Polyp When:_____
- [ ] Colon Polyp When:_____
- [ ] Barretts Esophagus When:_____

Renal Endocrine

- ☐ No Renal Issues
- ☐ Diabetes When:_____
- ☐ Kidney Disease When:_____
- ☐ Thyroid disorder When:_____
- ☐ Disease of the Pancreas When:_____
- ☐ Dialysis When:_____

Neuro/Musculoskeletal

- ☐ No Neuro/Musculoskeletal Issues
- ☐ Arthritis When:_____
- ☐ Psychiatric Disorder When:_____
- ☐ Anxiety disorder When:_____
- ☐ Depression When:_____
- ☐ Stroke When:_____
- ☐ Dementia When:_____
- ☐ Migraines When:_____
- ☐ Musculoskeletal Disease When:_____
- ☐ Seizures When:_____
- ☐ Spinal Cord Injury When:_____
- ☐ TIA When:_____
- ☐ Vertigo When:_____
- ☐ Syncope (Fainting) When:_____

Women's Health

- ☐ Hysterectomy When:_____
- ☐ Menopause When:_____
- ☐ Pregnancy Waiver When:_____
- ☐ LMP When:_____

Other

- ☐ Blood Transfusion When:_____
- ☐ Anemia When:_____
- ☐ HIV/Aids When:_____
- ☐ Other When:_____
- ☐ Cancer When:_____
- ☐ Sickle Cell Trait When:_____
- ☐ Hemophilia When:_____
- ☐ Coagulation/Bleeding Disorders When:_____
- ☐ Obesity When:_____
- ☐ Weight When:_____
- ☐ Chemotherapy/Radiation When:_____
- ☐ Multiple myeloma When:_____

Previous Procedures

- ☐ None

- ☐ Appendectomy When:_____
- ☐ C-Section When:_____
- ☐ Colon Resection When:_____
- ☐ Gallbladder removed When:_____
- ☐ Hiatal Hernia When:_____
- ☐ Hysterectomy When:_____
- ☐ Stomach/Bowel/ Colon Surgery When:_____
- ☐ Ulcer Surgery When:_____
- ☐ Heart Surgery When:_____
- ☐ Gastric By-Pass When:_____
- ☐ Gastric Band When:_____
- ☐ Tonsillectomy When:_____
- ☐ Tubal Ligation When:_____
- ☐ Angioplasty When:_____
- ☐ Umbilical hernia repair When:_____
- ☐ Inguinal Herniorraphy When:_____
- ☐ G-Tube When:_____
- ☐ Peg Tube When:_____
- Other:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

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

Alcohol

- ⬭ None

Type	Number
⬭ Rarely	
⬭ Daily	
⬭ More than 2 days/week	
⬭ 2 days or less/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

Type	Started	Quit	Quantity	Frequency
⬭ Cigarettes				
⬭ Cigar				
⬭ Chewing Tobacco				

Drug Use

- ⬭ None

Type	Number
⬭ I have used recreational drugs in the past	
⬭ I am currently using recreational drugs	
⬭ I have been treated for substance abuse	

Family Medical History

- ⬭ No knowledge of family history

No family history of

- ⬭ Adopted, family hx unknown
- ⬭ GI malignancies
- ⬭ IBS
- ⬭ Inflamatory Bowel Disease

	Mother	Father	Sister	Brother	Daughter	Son
Diagnoses						
Barrett's esophagus	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○

Breast Cancer	○ ○ ○ ○ ○ ○
Celiac Disease	○ ○ ○ ○ ○ ○
Colitis	○ ○ ○ ○ ○ ○
Colon Cancer	○ ○ ○ ○ ○ ○
Colon Polyps	○ ○ ○ ○ ○ ○
Crohn's Disease	○ ○ ○ ○ ○ ○
Liver Disease/Cirrhosis	○ ○ ○ ○ ○ ○
Pancreatic Disease	○ ○ ○ ○ ○ ○
Ulcerative Colitis	○ ○ ○ ○ ○ ○
Stomach Ulcer Disease	○ ○ ○ ○ ○ ○

Review Of Systems

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or hives	○	○

Cardiovascular

None	Y	N
angina/chest pain/w activity	○	○
irregular heart beat	○	○
shortness of breath	○	○
swelling in the legs	○	○
MI (Myocardial Infarction - Heart Attack)	○	○
Past Cardiovascular Surgery	○	○
cardiac stents	○	○
Pacemaker/ICD (Implantable Cardio Defibrillator)	○	○
CAD (Coronary Artery Disease)	○	○
HTN (High Blood Pressure)	○	○
CHF (Congestive Heart Failure)	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
weight gain	○	○
weight loss	○	○
weight stable	○	○
ETOH (Alcohol)/Substance Abuse	○	○

ENMT

None	Y	N
change in vision	○	○
hearing loss	○	○
glaucoma	○	○
mouth sores	○	○
ringing in ear	○	○
nose bleeds	○	○

Endocrine

None	Y	N
thyroid problems	○	○
diabetes	○	○
Type I Diabetes	○	○
Type II Diabetes	○	○
Obesity	○	○

Gastrointestinal

None	Y	N
abdominal pain	○	○
blood in stool	○	○
constipation	○	○
change in bowel habits	○	○
diarrhea	○	○
heartburn	○	○
jaundice	○	○
hepatitis	○	○
pancreatitis	○	○
poor appetite	○	○
nausea	○	○
gas	○	○
vomiting	○	○
regurgitation	○	○

Genitourinary

None	Y	N
blood in urine	○	○
heavy period	○	○
burning with urination	○	○
menopause	○	○
menstruating	○	○
Dialysis	○	○
UTI (Urinary Tract Infection)	○	○
Kidney failure	○	○

Hematologic/Lymphatic

None	Y	N
past transfusion	○	○
history of anemia	○	○
low platelets	○	○
on blood thinners	○	○
Hepatitis	○	○

Integumentary

None	Y	N
itching	○	○
rashes	○	○

Musculoskeletal

None	Y	N
back pain	○	○
joint pain	○	○
swollen joints	○	○
muscle pain	○	○
Neck pain	○	○
Arthritis	○	○

Neurological

None	Y	N
headaches	○	○
seizures	○	○
stroke	○	○
Migraines	○	○
seizures w/ in 30 days	○	○
CVA (Cerebrovascular Accident - Stroke)	○	○
TIA (Transient Ischemic Attack - Stroke)	○	○

Psychiatric

None	Y	N
chronic anxiety	○	○
depression	○	○

Respiratory

None	Y	N
chronic cough	○	○
coughing up blood	○	○
positive TB test	○	○
wheezing	○	○
Asthma	○	○
Sleep Apnea	○	○
O2 Use	○	○
COVID-19	○	○
PE (pulmonary embolism)	○	○
SOB (Shortness of Breath)	○	○
DOE (Dyspnea on Exertion)	○	○
COPD (Chronic Obstructive Pulmonary Disease)	○	○

trouble swallowing
bloating
incontinence
fecal urgency
rectal pain
rectal bleeding
rectal burning
belching
hemorrhoids

Reminder Preference

I would like to receive preventive care and follow up care reminders.

Yes No

Reviewed with

Patient Parent Guardian Not Present

Signature

Signature Date