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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

MRN:_____ Date Of Birth:_____

Age:_____

Allergies

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

☐ Latex ☐ IV dye Other:_____ Other:_____ Other:_____

Current Medications

☐ None

Name	Dose	How taken?

Pharmacy

Name	Address	Phone

Immunizations

☐ None

☐ Hepatitis A When:_____

☐ Hepatitis B When:_____

☐ Pneumococcal conjugate When:_____

☐ Flu vaccine A/B injection When:_____

☐ Meningococcal conjugate When:_____

☐ Zoster (Live) When:_____

☐ HPV When:_____

Other:_____

Other:_____

Other:_____

Social History

Occupation:_____ Number of Children:_____

Alcohol

☐ None

Type	Quantity	Number	Frequency

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	Quantity	Frequency

Drug Use

☐ None

Type	Quantity	Frequency
☐ Marijuana		
☐ Other		

Diagnostic Studies / Tests

☐ None

☐ TB Quantiferron or skin test When:_____
☐ Cocci titers When:_____
☐ Hep A/ B/ C antibodies When:_____
☐ JCV Antibody When:_____
☐ Celiac serology When:_____
☐ TPMT Geno/Phenotype When:_____
☐ Liver Biopsy When:_____
☐ DEXA/Bone density When:_____
☐ Abdominal Ultrasound When:_____
☐ CT When:_____
☐ MRI When:_____
☐ Recent Hospitalization When:_____
☐ Labs within the last 3-months When:_____

Previous Procedures

☐ None

☐ EGD When:_____
☐ Colonoscopy When:_____
☐ Capsule endoscopy When:_____
☐ Endoscopic Ultrasound When:_____
☐ Esophageal manometry When:_____
☐ Bravo pH monitor When:_____
☐ Nissen Fundoplication When:_____
☐ Cholecystectomy When:_____
☐ Appendectomy When:_____
☐ Gastric By-Pass When:_____
☐ Small bowel surgery When:_____
☐ Hemorrhoid Surgery When:_____
☐ Hemorrhoid Banding When:_____
☐ Colon Resection When:_____
☐ Cardiac Ablation When:_____
☐ Carotid Stent When:_____
☐ CATH - Cardiac When:_____
☐ Coronary artery bypass surgery When:_____
☐ Heart Valve (aortic or mitral) When:_____
☐ Pacemaker or defibrilator When:_____
☐ Thyroidectomy When:_____
☐ Hysterectomy When:_____
☐ Joint replacement When:_____
☐ Abdominal hernia repair When:_____
Other:_____
Other:_____
Other:_____

Past or Present Medical Conditions

☐ None

☐ GI bleed
When:

☐ Irritable Bowel Syndrome
When:

☐ Diverticulosis
When:

☐ Diverticulitis
When:

☐ Ulcerative Colitis
When:

☐ Crohn's Disease
When:

☐ Colon polyps
When:

☐ Colon cancer
When:

☐ Helicobacter pylori infection
When:

☐ GERD
When:

☐ Barrett's Esophagus
When:

☐ Peptic ulcer disease
When:

☐ Esophageal Stricture
When:

☐ Celiac Disease
When:

☐ Gallstones
When:

☐ Liver Problems
When:

☐ Elevated liver enzymes
When:

☐ Cirrhosis
When:

☐ Hepatitis C
When:

☐ Hepatitis B
When:

☐ Hepatitis other
When:

☐ Fatty Liver
When:

☐ Pancreatitis
When:

☐ Pancreatic cancer
When:

☐ Esophageal Cancer
When:

☐ Gastric Cancer
When:
Other:

Other:

Other:

Other:

Other:

Cardiac

☐ Heart Valve replacement
When:

☐ Endocarditis
When:

☐ Atrial Fibrillation
When:

☐ Arrhythmia
When:

☐ Angina
When:
Other:

☐ MI/heart attack
When:

☐ Hypertension
When:

☐ Cardiac Stents
When:

Pulmonary

☐ Asthma
When:

☐ COPD
When:

☐ Pulmonary embolus
When:

☐ Pneumonia
When:

☐ Valley Fever
When:
Other:

☐ Deep vein thrombosis
When:
Other:

☐ Sleep apnea
When:

☐ Lung Cancer
When:

Genito/urinary

☐ Urinary Tract Infections
When:

☐ Urinary Incontinence
When:

☐ Uterine Cancer
When:

☐ Kidney Cancer
When:

☐ Kidney Disease
When:

☐ kidney stones
When:
Other:

☐ Kidney transplant
When:

☐ Prostate Cancer
When:

☐ Ovarian Cancer
When:

Endocrine

☐ Hypothyroidism
When:

☐ Hyperthyroidism
When:

☐ Diabetes
When:
Other:

☐ Hyperlipidemia
When:

☐ Osteoporosis
When:

☐ Adrenal insufficiency
When:

Hema/Immuno:

☐ Blood transfusion
When:

☐ Anemia
When:

☐ Iron Deficiency
When:
Other:

☐ Immunodeficiency
When:
Other:

☐ Breast cancer
When:

☐ Lymphoma
When:

Neurological

☐ Epilepsy or seizures
When:

☐ TIA/Mini-stroke
When:
Other:

☐ Stroke
When:

☐ Neuropathy
When:

☐ Migraine
When:

Psychiatric

☐ Depression
When:
Other:

☐ Bipolar
When:

☐ Anxiety
When:

☐ Panic disorder
When:

Opthamological	☐ Glaucoma When:_____ Other:_____	☐ Blind When:_____	☐ Cataracts When:_____	Other:_____
Dermatological	☐ Psoriasis When:_____ Other:_____	☐ Skin Cancer-non melanoma When:_____	☐ Melanoma When:_____	☐ Hair loss When:_____
Ear / Nose / Throat	☐ Hearing loss When:_____	☐ Sinus disease When:_____	☐ Throat Cancer When:_____	Other:_____
Rheumatologic	☐ Gout When:_____ ☐ Scleroderma When:_____	☐ Osteoarthritis When:_____ ☐ Systemic Lupus When:_____	☐ SJogrens When:_____ ☐ Fibromylagia When:_____	☐ Rheumatoid arthritis When:_____
Additional social	☐ High risk sexual esposures When:_____	☐ Tatoos When:_____	☐ Piercings When:_____	☐ Occupational exposures When:_____

Family Medical History

☐ No knowledge of family history

No family history of

☐ colon cancer
☐ colon polyps
☐ Crohn's Disease
☐ IBD
☐ liver disease
☐ pancreatic cancer
☐ ulcerative colitis

Diagnoses	Mother	Father	Brother	Sister	Daughter	Son	Grandmother	Grandfather	Aunt	Uncle	Other	Unknown
Colon Cancer	○	○	○	○	○	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○	○	○	○	○	○
Pancreatic cancer	○	○	○	○	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○	○	○	○	○	○
Cervical Cancer	○	○	○	○	○	○	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○	○	○	○	○	○	○
Liver cirrhosis/disease	○	○	○	○	○	○	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○	○	○	○	○

Review Of Systems

	Yes	No
Allergic/Immunologic		
None		
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○
Food allergies	○	○
Constitutional		
None		
fatigue	○	○
fever	○	○
chills	○	○
loss of appetite	○	○
weight gain	○	○
weight loss	○	○
post-prandial fullness	○	○
ENMT		
None		
dizziness	○	○
nose bleeds	○	○
loss of vision	○	○
double vision	○	○
hoarseness of voice	○	○
Post nasal drip	○	○
Vertigo	○	○
Endocrine		
None		
hair loss	○	○
heat intolerance	○	○
Cold intolerance	○	○
Flushing	○	○
Cardiovascular		
None		
chest pain	○	○
shortness of breath with exercise	○	○
irregular heart beat	○	○
palpitations	○	○
ankle swelling	○	○
fainting	○	○
Respiratory		
None		
asthma	○	○
cough	○	○
shortness of breath	○	○
excessive sputum	○	○
shortness of breath with exercise	○	○
wheezing	○	○
Oxygen dependence	○	○
hemoptysis	○	○
Sleep apnea	○	○

	Yes	No
Gastrointestinal		
None		
abdominal pain	○	○
Abdominal distention/bloating	○	○
heartburn	○	○
reflux	○	○
gas	○	○
Indigestion	○	○
difficulty swallowing/dysphagia	○	○
solids stick with swallowing	○	○
liquids stick with swallowing	○	○
coughing with swallowing	○	○
Early Satiety	○	○
nausea	○	○
vomiting	○	○
change in bowel habits	○	○
diarrhea	○	○
constipation	○	○
straining with defecation	○	○
rectal bleeding	○	○
wipe bleeding	○	○
Black Stools	○	○
Anal pain	○	○
Anal itching	○	○
Anal burning	○	○
Anal pressure	○	○
Anal leaking/soiling	○	○
fecal incontinence	○	○
Ascites	○	○
jaundice	○	○
Elevated liver enzymes	○	○
enlarged liver	○	○
pancreatitis	○	○
Genitourinary		
None		
dark urine	○	○
urinary burning	○	○
frequent urination	○	○
hematuria	○	○
urinary incontinence	○	○
urinary hesitancy	○	○
Hematologic/Lymphatic		
None		
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○
anemia	○	○

	Yes	No
Integumentary		
None		
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
rashes	○	○
Open wounds or sores	○	○
Seasonal allergies	○	○
Musculoskeletal		
None		
arthritis	○	○
joint pain	○	○
back pain	○	○
gout	○	○
muscle weakness	○	○
stiffness	○	○
Neurological		
None		
dizziness	○	○
fainting	○	○
migraine	○	○
headaches	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○
vertigo	○	○
Psychiatric		
None		
anxiety	○	○
panic attacks	○	○
depression	○	○
paranoia	○	○
difficulty sleeping	○	○
hallucinations	○	○
Schizophrenia	○	○