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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

Ethnicity

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Patient declines to specify
- ◯ Unknown

Sex

- ◯ Male
- ◯ Female
- ◯ Other

Preferred Language

- ◯ English
- ◯ Haitian; Haitian Creole
- ◯ Spanish; Castilian
- ◯ Patient declines to specify

Contact Preference

- ◯ Any method
- ◯ Mobile/cell Phone
- ◯ Home Phone
- ◯ Patient Portal
- ◯ Letter/mail
- ◯ Patient declines to specify

Allergies

- ◯ Patient has no known allergies
- ◯ Patient has no known drug allergies

Medications	◯ Propofol	◯ midazolam	◯ Opioids - Morphine Analogues	Other: ________
	Other: ________	Other: ________	Other: ________	Other: ________
Food	◯ Soybean Products	◯ Eggs	Other: ________	Other: ________
Environmental	◯ Latex	◯ adhesive tape	◯ Chlorhexidine skin antiseptic	Other: ________

Current Medications

- [ ] None

Name	Dose	How taken?

Immunizations

- [ ] None

- [ ] Flu Vaccine
  When:______________
- [ ] Prevnar 13 pneumonia
  When:______________
- [ ] pneumococcal polysaccharide pneumonia PPV23
  When:______________
- [ ] Hepatitis B
  When:______________
- [ ] Shingles
  When:______________

Diagnostic Studies/Tests

- [ ] None

- [ ] Colonoscopy
  When:______________
- [ ] Capsule Endoscopy
  When:______________
- [ ] Upper Endoscopy
  When:______________
- [ ] cardiac catheterization
  When:______________
- [ ] cardiac stress test
  When:______________
- [ ] Virtual CT Colonoscopy
  When:______________
- [ ] Cologuard
  When:______________
- [ ] Fecal Occult Blood Test
  When:______________

Past or Present Medical Conditions

- ◯ None

◯ Anemia	◯ Anxiety	◯ Arthritis	◯ Asthma	◯ Atrial Fibrillation
◯ Autoimmune Disease	◯ Barrett's Esophagus	◯ Blood Clots	◯ Cancer	◯ C-Difficile Diarrhea
◯ Celiac Disease	◯ Chronic Headaches	◯ Chronic lung disease	◯ Dementia or Memory Problems	◯ Diverticulitis: Infection of colon pockets
◯ Diverticulosis: Colon pockets	◯ Diabetes Mellitus-Diet controlled	◯ Diabetes Mellitus- on Insulin	◯ Diabetes Mellitus controlled with pills	◯ Prostate enlargement
◯ Reflux / heartburn	◯ Esophageal Stricture	◯ Esophagitis	◯ Gall bladder disease	◯ Glaucoma
◯ Heart Attack	◯ Hemmhorids	◯ Hepatitis A	◯ Hepatitis B, chronic	◯ Hepatitis C
◯ Hiatal hernia	◯ HIV / AIDS	◯ Hypertension	◯ High Cholesterol	◯ High lipids / fats
◯ H. pylori infection	◯ Irritable Bowel Syndrome	◯ Kidney Disease	◯ Kidney Dialysis	◯ MRSA
◯ Sleep apnea syndrome, obstructive	◯ Pancreatitis	◯ Paralysis	◯ Parkinsonism	◯ Thyroid disorder
◯ Tuberculosis	◯ Ulcerative Colitis	◯ Stomach Ulcer	◯ Stroke or TIA	◯ Substance Abuse Disorder
◯ Tuberculosis exposure	◯ Coronary Artery Disease/ Blockage	◯ Congestive Heart Failure	◯ seasonal allergies	◯ environmental allergies
◯ Crohn's Disease	◯ Seizure disorder	◯ Mental Health Condition	◯ Liver disease	◯ Lactose Intolerance
◯ Colon polyps	◯ Colon Cancer	◯ Rectal Cancer	◯ Admitted to hospital within past 90 days	◯ Problems with anesthesia
◯ Travel outside the US in past 30 days	Other: ____________	Other: ____________		

Previous Procedures

- ⬭ None

⬭ AICD/Internal Defibrillator	⬭ Amputation	⬭ Appendectomy	⬭ C-Section	⬭ Cataract surgery
⬭ Colon Resection	⬭ Colostomy bag	⬭ Esophageal Dilitation	⬭ Gallbladder Removed	⬭ Heart Bypass Surgery
⬭ Heart Stent / Angioplasty	⬭ Heart Valve Replacement	⬭ Hemorrhoidectomy	⬭ Hysterectomy	⬭ Insertion of any metal, pins, screws
⬭ Insertion of any ports, filters, shunts	⬭ Joint Surgery/Replacement	⬭ Kidney Procedure	⬭ Liver Biopsy	
⬭ Lung surgery	⬭ Mastectomy	⬭ Obesity Surgery	⬭ Tonsillectomy	⬭ Transplant Surgery
⬭ Tubal Ligation	⬭ Pacemaker	⬭ Thyroidectomy	⬭ Stomach Surgery	⬭ Feeding Tube
⬭ Prostate Surgery	Other: ______			

Family Medical History

⬭ No knowledge of family history

No family history of ⬭ Colon cancer ⬭ Polyps

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son
Family member with Colon Polyps before age 60	O	O	O	O	O	O
Family member with Colon Cancer before age 60	O	O	O	O	O	O
Family member with Colon Cancer after age 60	O	O	O	O	O	O
Family member with Rectal Cancer before age 60	O	O	O	O	O	O
Family member with Rectal Cancer after age 60	O	O	O	O	O	O
Stomach Cancer	O	O	O	O	O	O
Esophageal Cancer	O	O	O	O	O	O
Liver Disease	O	O	O	O	O	O
Liver Cancer	O	O	O	O	O	O
Family history of pancreatic cancer	O	O	O	O	O	O
Familial multiple polyposis syndrome	O	O	O	O	O	O

Social History

Occupation:__________________________________

Marital Status

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Separated
- ◯ Widowed
- ◯ Civil Union

Alcohol

- ◯ None

Type	Quantity	Number	Frequency
◯ Beer			
◯ Wine			
◯ Liquor			

Caffeine

- ◯ None
- ◯ Coffee
- ◯ Soda
- ◯ Energy Drinks
- ◯ Tea

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

Drug Use

- ◯ None

Type	Quantity	Number	Frequency
◯ Marijuana			
◯ IV drugs			
◯ Any medications obtained without a prescription			
◯ Heroin			
◯ Other			

Review Of Systems

Constitutional	Y	N
fever		
night sweats		
loss of appetite		
weight gain, unexplained		
weight loss, unexplained		
pregnant		
breast feeding		

Allergic/Immunologic	Y	N
chronic infections		
frequent colds		

ENMT	Y	N
hearing loss		
loss or change in vision		
sore throat		
difficulty swallowing		
hoarseness		
broken or loose teeth		

Cardiovascular	Y	N
chest pain		
irregular heart beat		
palpitations		
shortness of breath while lying flat		
swelling of hands or feet		

Respiratory	Y	N
cough		
shortness of breath at rest		
shortness of breath with normal activities		
wheezing		
snoring		

Gastrointestinal	Y	N
heartburn		
abdominal pain		
nausea		
vomiting		
bloating		
belching		
change in bowel habits		
constipation		
diarrhea		
excessive passing of gas		
dark stools		
bloody stools		
mucous in stool		
rectal bleeding		
Anal/rectal pain		
hemorrhoids		
pain with bowel movements		
soiling/incontinence		
pain on swallowing		

Genitourinary	Y	N
poor stream of urine		
frequent urination		
frequent urinary infections		

Hematologic/Lymphatic	Y	N
easy bruising		
prolonged bleeding		

Integumentary	Y	N
lesions		
rashes		
bruises		
draining wounds		
infection		

Musculoskeletal	Y	N
back pain		
joint pain		
muscle weakness		
general muscle aches		

Neurological	Y	N
fainting		
frequent headaches		
numbness or tingling		
tremors		
poor balance		
memory loss		
speech problems		
falls in past 3 months		
dizziness		

Psychiatric	Y	N
nervousness		
panic attacks		

Pharmacy

Name | Address | Phone

Consent to Import Medication History

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

⬭ Yes ⬭ No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

⬭ Yes ⬭ No

Reminder Preference

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

⬭ Yes ⬭ No

Signature

Signature | Date