

Patient Interview Form

PLACE PATIENT LABEL HERE

Patient email _____

Name: _____ Birth Date: _____ Gender: _____

Race: (check any that apply) White/Caucasian Black or African-American Asian American Indian or Alaska Native
 Native Hawaiian or Pacific Islander Unknown Patient Declines to Specify Prohibited by state law

Ethnicity: (check one) Hispanic or Latino Not Hispanic or Latino Patient Declines to Specify.

Preferred Language: English Spanish Chinese Russian Patient Declines to Specify Other _____

Contact Preference: Letter Portal (Email) Patient Declines to Specify

Referring Physician: _____ Primary Care Physician: _____

Local Pharmacy Name/ Address: _____

Mail-Order Pharmacy Name/ Address: _____

PRESENTING PROBLEM: Use the space below to describe the reason for your visit and your special concerns. If you have questions, please write them down so you will not forget them. Thank you.

MEDICATION ALLERGIES: List the medications or injections that have caused bad reactions. Include your reaction (hives, rash, itching, headache, nausea, diarrhea, passed out, shock, shortness of breath).

Medication / Dose	Reaction	Medication / Dose	Reaction

Do you have a allergies to following NO YES **If yes check box and describe reaction:**
 Latex Eggs Soy _____

MEDICATIONS: Please list the medications that you are taking (prescription, over-the-counter, and supplements), including any NSAIDs or Anti-inflammatory medications that you are currently taking (Aspirin, Advil/ibuprofen, Aleve/naproxen, Celebrex (celecoxib), Voltaren (diclofenac): Attach additional sheet if needed.

Medication/ Dose	How often per day?	Medication/ Dose	How often per day?

IMMUNIZATIONS: Have you been immunized for any of the following?

Flu vaccine Hep A Hep B Pneumonia vaccine Herpes zoster (shingles) vaccine
 When: _____ When: _____ When: _____ When: _____ When: _____

Cardiac

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Abnormal Heartbeats | <input type="checkbox"/> Angina | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Cardiac Stents |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Hyperlipidemia
(Elevated Cholesterol) | <input type="checkbox"/> Hypertension
(High Blood Pressure) |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker | | |
- Other Heart Trouble (List): _____

Respiratory

- | | | | | | |
|---------------------------------|-------------------------------|------------------------------------|------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> TB Exposure/ Treatment |
|---------------------------------|-------------------------------|------------------------------------|------------------------------------|--------------------------------------|---|

Gastrointestinal

- | | | | |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> Cancer of the GI Tract | <input type="checkbox"/> Crohn's | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Colon Polyps |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Fecal Incontinence | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Jaundice(yellow eyes / skin) | <input type="checkbox"/> Peptic Ulcer |
| <input type="checkbox"/> Ulcerative Colitis | | | |

GYN / OB (Female must complete)

- | | | | |
|-----------------------------|---|--|---|
| Number of Pregnancies _____ | <input type="checkbox"/> Menstrual or Pelvic Problems | <input type="checkbox"/> Date of Last Period _____ | <input type="checkbox"/> Birth Control Method _____ |
| Number of Live births _____ | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tubal Ligation |
| | | <input type="checkbox"/> Menopause greater than 6 months | |

Other

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Seizures (fits or blackouts) | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Stroke, Mini-stroke (TIA/CVA) | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Back Pain (chronic) |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Victim of Verbal Abuse/ Violence | |
| <input type="checkbox"/> History of MRSA | | <input type="checkbox"/> Other cancers (list) _____ | |
| <input type="checkbox"/> Collagen Vascular Disease (lupus, scleroderma, vasculitis, other) | | _____ | |
| <input type="checkbox"/> Other Medical Conditions (List): _____ | | _____ | |

Hospitalizations for Past Illnesses	Year	Hospital	Physician
Procedures or Surgeries	Year	Hospital	Physician
Diagnostic Studies or Tests (include previous colonoscopy & upper endoscopy)	Year	Hospital	Physician

Social History

- | | | |
|---|---|---|
| Occupation _____ | Marital Status _____ | Number of Children _____ |
| Alcohol Use
Amount? Frequency?
<input type="checkbox"/> Beer _____ Per _____
<input type="checkbox"/> Wine _____ Per _____
<input type="checkbox"/> Spirits _____ Per _____
<input type="checkbox"/> Never | Caffeine Use
<input type="checkbox"/> Diet Soda
<input type="checkbox"/> Soda
<input type="checkbox"/> Coffee
<input type="checkbox"/> Tea
<input type="checkbox"/> Never | Tobacco Use
<input type="checkbox"/> Light smoker (< 10 cigarettes/day)
<input type="checkbox"/> Heavy smoker (>10 cigarettes/day)
Date Started _____
<input type="checkbox"/> Former smoker quit: Year _____
<input type="checkbox"/> Other/Vape/eCig <input type="checkbox"/> Never smoker |
| | | Recreational Drug / Marijuana Use
<input type="checkbox"/> Never <input type="checkbox"/> Yes (see below)
<input type="checkbox"/> Marijuana: <input type="checkbox"/> edible <input type="checkbox"/> smoke <input type="checkbox"/> topical
<input type="checkbox"/> Other _____
Frequency _____
<input type="checkbox"/> Former quit: year _____ |

Exercise Yes No Frequency _____
 Type _____

PLACE PATIENT LABEL HERE

Family Medical History No knowledge of family history.

No Family History of Colon Cancer. No Family History of Colon Polyps.

Mother: Living? Yes No Age now, or at death _____ **Father:** Living? Yes No Age now, or at death _____

Besides parents, do you have any brothers, sisters, sons or daughters with the following conditions? Fill in the blanks with their relation to you and mark the condition (please specify living or deceased).

Any Family History Of:	Mother	Father							
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peptic Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cause of Death _____

Have You Had Any of These Symptoms in the Last 6 Months? (Check any that apply)

Cardiovascular	Gastrointestinal	Musculoskeletal
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Abdominal swelling	<input type="checkbox"/> Back pain
<input type="checkbox"/> Difficulty breathing while lying down	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Gout
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Constipation	<input type="checkbox"/> Joint deformity
<input type="checkbox"/> Swelling of your arms or legs	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Short of breath with exercise	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Muscle weakness
	<input type="checkbox"/> Fecal Incontinence	<input type="checkbox"/> Stiffness
Constitutional	<input type="checkbox"/> Gas	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Heartburn	Respiratory
<input type="checkbox"/> Fever	<input type="checkbox"/> Nausea	<input type="checkbox"/> Asthma
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Cough
<input type="checkbox"/> General feeling of being unwell	<input type="checkbox"/> Stomach cramps	<input type="checkbox"/> Short of breath
<input type="checkbox"/> Sweats	<input type="checkbox"/> Yellow skin or eyes	<input type="checkbox"/> Excessive sputum
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Coughing up blood
<input type="checkbox"/> Weight loss	Genitourinary	<input type="checkbox"/> Wheezing
	<input type="checkbox"/> Decrease in urine flow	Neurological
ENMT	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Ear pain	<input type="checkbox"/> Frequent urinary infections	<input type="checkbox"/> Fainting
<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Frequent headaches
<input type="checkbox"/> Nasal obstruction	<input type="checkbox"/> Presence of blood in the urine	<input type="checkbox"/> Migraine
<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Excessive urination at night	<input type="checkbox"/> Numbness or tingling
<input type="checkbox"/> Light sensitivity	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Seizures
<input type="checkbox"/> Sore throat		<input type="checkbox"/> Tremors
<input type="checkbox"/> Double vision	Hematologic/ Lymphatic	<input type="checkbox"/> Vertigo
	<input type="checkbox"/> Bleeding gums	
	<input type="checkbox"/> Swollen lymph nodes	Psychiatric
	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Anxiety
	<input type="checkbox"/> Prolonged bleeding	<input type="checkbox"/> Depression
We want to inform you that we will be regularly sending you information regarding preventative care and health care reminders. Healthcare procedures such as vaccinations, and diagnoses such as cancer and infectious disease are reported to State and Federal registries, as mandated by law. To insure accuracy, your prescribed medication history may be imported into your medical record from your pharmacy. All of these are allowed and protected by Federal privacy laws.		<input type="checkbox"/> Hallucinations
		<input type="checkbox"/> Nervousness
		<input type="checkbox"/> Panic attacks
		<input type="checkbox"/> Paranoia
		<input type="checkbox"/> PTSD

Date: _____

PLACE PATIENT LABEL HERE

Patient Signature: _____

Date: _____ Reviewed

By: _____