

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

Unknown Patient declines to specify

Ethnicity

Hispanic or Latino Not Hispanic or Latino Patient declines to specify

Sex

Male Female Other

Preferred Language

English Spanish; Castilian Patient declines to specify Other: _____

Contact Preference

Portal message Home Phone Mobile phone Work phone Patient declines to specify

Immunizations

None

Hep A Hep B

When: _____ When: _____

Diagnostic Studies/Tests

- None
- In the past 12 months I have had xRay tests In the past 12 months I have had Lab tests Colonoscopy EGD- Esophagogastroduodenoscopy

Previous Procedures

None

- Gastrointestinal**
- | | | | |
|---|--|--|---|
| <input type="radio"/> Appendectomy | <input type="radio"/> Ulcer surgery | <input type="radio"/> Hemorrhoidectomy | <input type="radio"/> Hernia repair |
| <input type="radio"/> Inguinal Herniorraphy | <input type="radio"/> Gallbladder removed/Cholecystectomy | <input type="radio"/> Anal Fissure | |
| <input type="radio"/> Adhesion Surgery | <input type="radio"/> Weight Loss Surgery: Gastric Band/Lap Band | <input type="radio"/> Weight Loss Surgery: Gastric By-Pass | <input type="radio"/> Large Intestine/Colon Surgery |
| <input type="radio"/> ERCP | <input type="radio"/> Endoscopic Ultrasound (EUS) | <input type="radio"/> Liver Biopsy | <input type="radio"/> Small Bowel Capsule |

Other: _____

- Cardiovascular Pulmonary**
- | | | | |
|--|--|---|--|
| <input type="radio"/> Carotid Stent Left | <input type="radio"/> Coronary Artery Cath | <input type="radio"/> Heart valve replacement | <input type="radio"/> Cardiac Ablation |
| <input type="radio"/> Aortic Aneurysm Repair | <input type="radio"/> Coronary artery bypass surgery | <input type="radio"/> Pacemaker | <input type="radio"/> Defibrillator |

Other: _____

- OB/GYN**
- | | | | |
|---|--|--|--|
| <input type="radio"/> Hysterectomy | <input type="radio"/> Tubal Ligation | <input type="radio"/> Breast Aspiration/Biopsy | |
| <input type="radio"/> Breast Removal/Mastectomy | <input type="radio"/> Ovary Removed/Oophorectomy | Other: _____ | |

- ENT**
- | | | | |
|-------------------------------------|-------------------------------------|--------------|--|
| <input type="radio"/> Tonsillectomy | <input type="radio"/> Sinus Surgery | Other: _____ | |
|-------------------------------------|-------------------------------------|--------------|--|

- Endocrinology**
- | | | | |
|-------------------------------------|--------------------------------------|---|--------------|
| <input type="radio"/> Thyroidectomy | <input type="radio"/> Thyroid Biopsy | <input type="radio"/> Parathyroidectomy | Other: _____ |
|-------------------------------------|--------------------------------------|---|--------------|

- Urology**
- | | | | |
|--|---|------------------------------------|---|
| <input type="radio"/> Prostatectomy | <input type="radio"/> Bladder Resection | <input type="radio"/> Bladder Lift | <input type="radio"/> Bladder Surgery (other) |
| <input type="radio"/> Prostate Surgery | <input type="radio"/> Nephrectomy | Other: _____ | |

- Orthopedic and Neurological**
- | | | | |
|---|---|--|--|
| <input type="radio"/> Knee Surgery (Right) | <input type="radio"/> Knee Surgery (Left) | <input type="radio"/> Hip Replacement (Right) | <input type="radio"/> Hip Replacement (Left) |
| <input type="radio"/> Shoulder Surgery | <input type="radio"/> Hand Surgery | <input type="radio"/> Craniotomy (Brain Surgery) | <input type="radio"/> Spinal Surgery |

Other: _____

Other Surgery Not Listed

Surgery #1: _____

Surgery #2: _____

Surgery #3: _____

Past or Present Medical Conditions

None

- | | | | | |
|-------------------------|--|--|---|--|
| Gastrointestinal | <input type="radio"/> Hepatitis B | <input type="radio"/> Hepatitis C | <input type="radio"/> Cirrhosis | <input type="radio"/> Liver disease |
| | <input type="radio"/> H. Pylori | <input type="radio"/> Pancreatitis | <input type="radio"/> Gallstones | <input type="radio"/> Gastric Cancer |
| | <input type="radio"/> Colon Cancer | <input type="radio"/> GERD | <input type="radio"/> Colitis | <input type="radio"/> Celiac |
| | <input type="radio"/> IBS | <input type="radio"/> Heartburn | <input type="radio"/> Diverticulitis | <input type="radio"/> Ulcer |
| | <input type="radio"/> Crohn's Disease | <input type="radio"/> Peptic ulcer disease | <input type="radio"/> Barrett's esophagus | <input type="radio"/> Lactose/milk intolerance |
| | <input type="radio"/> Ulcerative Colitis | <input type="radio"/> Bile Duct Cancer | <input type="radio"/> Esophageal Cancer | <input type="radio"/> Pancreatic Cancer |

Other: _____

- | | | | | |
|-----------------------|---|--|---|--|
| Cardiovascular | <input type="radio"/> High blood pressure | <input type="radio"/> High cholesterol | <input type="radio"/> High triglycerides | <input type="radio"/> Heart attack |
| | <input type="radio"/> Angina | <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Atrial Fibrillation | <input type="radio"/> Other heart rhythm disturbance |

Other: _____

- | | | | | |
|-------------------------|--|------------------------------------|--------------------------------|-----------------------------------|
| Respiratory/Lung | <input type="radio"/> Chronic bronchitis | <input type="radio"/> Emphysema | <input type="radio"/> Asthma | <input type="radio"/> Sleep apnea |
| | <input type="radio"/> Pulmonary Edema | <input type="radio"/> Tuberculosis | <input type="radio"/> C.O.P.D. | Other: _____ |

- | | | | | |
|------------------|----------------------------------|---------------------------------|---------------------------|--------------------------------|
| Neurology | <input type="radio"/> Migraines | <input type="radio"/> Stroke | <input type="radio"/> TIA | <input type="radio"/> Seizures |
| | <input type="radio"/> Neuropathy | <input type="radio"/> Alzheimer | Other: _____ | |

- | | | | | |
|------------------|--------------------------------------|---------------------------------------|---|---------------------------------------|
| Endocrine | <input type="radio"/> Osteoporosis | <input type="radio"/> Osteopenia | <input type="radio"/> Diabetes Mellitus | <input type="radio"/> Hyperthyroidism |
| | <input type="radio"/> Hypothyroidism | <input type="radio"/> Thyroid - other | Other: _____ | |

- | | | | | |
|----------------------|-------------------------------------|--------------------------------------|---------------------------|--------------|
| Genitourinary | <input type="radio"/> Kidney stones | <input type="radio"/> Kidney failure | <input type="radio"/> STD | Other: _____ |
|----------------------|-------------------------------------|--------------------------------------|---------------------------|--------------|

- | | | | | |
|------------|--------------------------------|---------------------------------|--------------------------------------|--|
| Eye | <input type="radio"/> Glaucoma | <input type="radio"/> Cataracts | <input type="radio"/> Conjunctivitis | <input type="radio"/> Macular Degeneration |
|------------|--------------------------------|---------------------------------|--------------------------------------|--|

Other: _____

- | | | | |
|---------------------|---------------------------------|--|--------------|
| Rheumatology | <input type="radio"/> Arthritis | <input type="radio"/> Autoimmune Disease | Other: _____ |
|---------------------|---------------------------------|--|--------------|

- | | | | | |
|-------------------|--|----------------------------------|-------------------------------------|---------------------------------------|
| Psychology | <input type="radio"/> Anxiety disorder | <input type="radio"/> Depression | <input type="radio"/> Panic attacks | <input type="radio"/> Eating Disorder |
|-------------------|--|----------------------------------|-------------------------------------|---------------------------------------|

Other: _____

- | | | | | |
|-------------------|------------------------------|--------------------------------------|---------------------------|--------------|
| Hematology | <input type="radio"/> Anemia | <input type="radio"/> Blood disorder | <input type="radio"/> HIV | Other: _____ |
|-------------------|------------------------------|--------------------------------------|---------------------------|--------------|

- | | | | | |
|-----------------|-------------------------------------|---------------------------------------|--|--------------|
| Oncology | <input type="radio"/> Breast Cancer | <input type="radio"/> Prostate Cancer | <input type="radio"/> Renal Cell Carcinoma | Other: _____ |
|-----------------|-------------------------------------|---------------------------------------|--|--------------|

Pharmacy

Name	Address	Phone
------	---------	-------

Current Medications

None

Name	Dose	How taken?
------	------	------------

_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

- Patient has no known allergies Patient has no known drug allergies
- aspirin Codeine Demerol Fentanyl Flagyl
 Iodine Levaquin Cipro morphine Penicillins
 Sulfa Versed Latex Eggs Shellfish
 Nuts midazolam Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

- Single Married Divorced Separated Widowed
 Civil Union Unknown Other

Alcohol

- None
 Less than 7 drinks per week More than 7 drinks per week I quit using alcohol

Drug Use

- None
 I have used recreational drugs in the past I am currently using recreational drugs I have been treated for substance abuse

Exercise

- None
 Exercise 1 - 2 days per week Exercise 3 days or more per week

Caffeine

- None
 Daily consumption of beverages containing caffeine Rarely consume beverages containing caffeine

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
 Cigar
 Cigarettes

