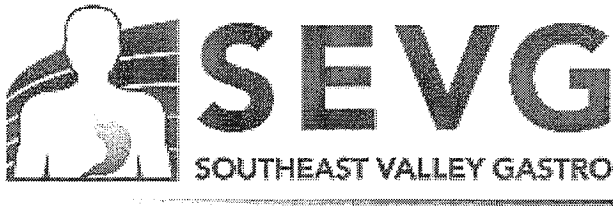

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

MRN:_____ Date Of Birth:_____

Age:_____ Notes:_____

Allergies

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

◯ Latex ◯ Codeine Sulfate ◯ Penicillins ◯ Iodine Containing Drugs ◯ Sulfa (Sulfonamides)

Other:_____

Current Medications

◯ None

Name	Dose	How taken?

Immunizations

◯ None

◯ PPD When:_____ ◯ Hep A When:_____ ◯ Hep B When:_____ ◯ Pneumovax When:_____ Other:_____

Diagnostic Studies/Tests

◯ None

◯ Abdominal MRI When:_____ ◯ Pelvic MRI When:_____ ◯ Abdominal CT When:_____ ◯ Pelvic CT When:_____ ◯ Abdominal U/S When:_____

◯ Pelvic Ultrasound When:_____	◯ Barium enema x-ray When:_____ Other:_____	◯ Barium swallow x-ray When:_____	◯ Cardiac catheterization When:_____	◯ Echocardiagram When:_____

Past or Present Medical Conditions

◯ None

GI	◯ Acid Reflux When:_____	◯ Gallstones When:_____	◯ Duodenal ulcer When:_____	◯ Stomach ulcer When:_____
	◯ Barrets esophagus When:_____	◯ Crohn's Disease When:_____	◯ Ulcerative colitis When:_____	◯ Hepatitis When:_____
	◯ Irritable bowel syndrome When:_____	Other:_____	Other:_____	
Rheumatology/ Hematology	◯ Arthritis When:_____	◯ Rheumatoid arthritis When:_____	◯ Fibromyalgia When:_____	◯ Anemia/iron deficiency When:_____
	◯ Osteoporosis When:_____	◯ Bleeding disorder When:_____		
Heart/Lung	◯ Angina When:_____	◯ Heart Attack When:_____	◯ Congestive Heart Failure When:_____	◯ Valvular heart disease When:_____
	◯ Atrial Fibrillation When:_____	◯ Pacemaker When:_____	◯ Defibrillator When:_____	◯ High blood pressure When:_____
	◯ High cholesterol When:_____	◯ Stroke When:_____	◯ Asthma When:_____	◯ C.O.P.D. When:_____
	◯ Sleep apnea When:_____	◯ Tuberculosis (TB) When:_____	◯ Valley Fever When:_____	
Endocrine/ Metabolic/Misc	◯ Diabetes When:_____	◯ Hypothyroidism When:_____	◯ Hyperthyroidism When:_____	◯ Kidney Disease When:_____
	◯ kidney stones When:_____	◯ Seizures When:_____	◯ Glaucoma When:_____	◯ Headaches When:_____
	◯ Depression When:_____	◯ Bipolar disorder When:_____	◯ Anxiety disorder When:_____	
Cancer	◯ Colon cancer When:_____	◯ Prostate Cancer When:_____	◯ Breast cancer When:_____	◯ Skin Cancer When:_____
	◯ Lung cancer When:_____	Other:_____		

Previous Procedures

◯ None

◯ Appendectomy When:_____	◯ Stomach Ulcer Surgery When:_____	◯ Bowel Resection When:_____	◯ Anti-reflux surgery When:_____	◯ Hernia Repair When:_____
◯ Gastric Bypass When:_____	◯ Lab Band When:_____	◯ Gallbladder removed When:_____	◯ Splenectomy When:_____	◯ Tonsillectomy When:_____

◯ Thyroidectomy When:_____	◯ Mastectomy R Breast When:_____	◯ Lumpectomy breast When:_____	◯ Heart valve replacement When:_____	◯ Cardiac stent When:_____
When:_____	◯ Lung surgery When:_____	◯ Hysterectomy When:_____	◯ Ovaries removed When:_____	◯ Ovary surgery When:_____
◯ TURP When:_____	◯ Prostatectomy When:_____	◯ Vasectomy When:_____	◯ Back Surgery When:_____	◯ Vascular Surgery When:_____
◯ Tubal Ligation When:_____	◯ Hip Replacement (left) When:_____	◯ Hip Replacement (right) When:_____	◯ Knee Replacement (left) When:_____	◯ Knee replacement (right) When:_____
◯ Hemorrhoid surgery When:_____	◯ Colonoscopy When:_____	◯ Upper Endoscopy When:_____	Other:_____	Other:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed
◯ Civil Union ◯ Unknown ◯ Other

Alcohol

◯ None

Type Quantity Frequency

_____

Caffeine

◯ None

Intake:_____ Intake:_____

Tobacco

Smoking Status

◯ Current every day smoker ◯ Current some day smoker ◯ Former smoker ◯ Never smoker
◯ Smoker, current status unknown ◯ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
◯ Chewing Tobacco				
◯ Smokeless				

Drug Use

◯ None

Type Quantity Frequency

_____

Exercise

◯ None

Type Quantity Frequency

_____

Family Medical History

○ No knowledge of family history

No family history of ○ Colon cancer ○ Polyps

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle
Colon Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Esophagus Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pancreas Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Ovarian Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Uterine Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Kidney Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Prostate Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pancreatitis	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Irritable Bowel Syndrome	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Eating Disorders	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Alcoholism	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Bleeding Disorders	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Review Of Systems

Constitutional

○ None

	Yes	No
loss of appetite	○	○
excessive appetite	○	○
fatigue	○	○
difficulty sleeping	○	○
lack of exercise	○	○
excessive sweating	○	○
weight gain	○	○
weight loss	○	○

ENMT

○ None

	Yes	No
blurred vision	○	○
double vision	○	○
eye pain - itchy watery eyes	○	○
cataracts	○	○
loss of hearing	○	○
ear pain	○	○
ringing in ears	○	○
dental problems	○	○
sore tongue	○	○
taste changes	○	○
swelling of gums	○	○
sore throat	○	○

Respiratory

○ None

	Yes	No
chronic cough	○	○
productive cough	○	○
coughs up blood	○	○
chronic bronchitis	○	○
sleep apnea	○	○

Cardiovascular

○ None

	Yes	No
palpitations	○	○
angina	○	○
dizziness	○	○
shortness of breath with activity	○	○
elevated on 2 or more pillows to breathe at night	○	○
swelling of feet/ankles	○	○
heart murmur	○	○

Gastrointestinal

○ None

	Yes	No
heartburn	○	○
difficulty swallowing	○	○
bloating	○	○
belching	○	○
nausea	○	○
vomiting	○	○
vomiting blood	○	○
abdominal pain	○	○
constipation	○	○
diarrhea	○	○
stool urgency	○	○
black stools	○	○
rectal bleeding	○	○

Musculoskeletal

○ None

	Yes	No
joint pain	○	○
muscle aches	○	○
back pain	○	○
joint swelling	○	○
joint pain from arthritis	○	○

Genitourinary

○ None

	Yes	No
nocturia	○	○
hematuria	○	○
urgency	○	○
difficulty starting urine	○	○
burning on urination	○	○
urinary incontinence	○	○
weak urine stream	○	○
prostate problems	○	○
lumps or masses on testicles	○	○
discharge from penis	○	○
painful testicles	○	○
menstral problems	○	○
breakthrough bleeding	○	○
premenstral tension	○	○
breasts implants	○	○
breast lump	○	○
excessive vaginal bleeding	○	○
postmenopausal	○	○
hot flashes	○	○
blood with intercourse	○	○

Integumentary

○ None

	Yes	No
chronic skin condition	○	○
recent rash	○	○
excessive itching	○	○
acne	○	○

Neurological

○ None

	Yes	No
dizziness	○	○
lightheadedness	○	○
vertigo	○	○
numbness or tingling	○	○
tremors	○	○
seizures	○	○
traumatic brain injury	○	○

Psychiatric

○ None

	Yes	No
difficulty making decisions	○	○
lack of concentration	○	○
depression	○	○
cries often	○	○
worries excessively	○	○
panic attacks	○	○
memory loss	○	○
desires psychiatric help	○	○

Endocrine

○ None

	Yes	No
excessive thirst	○	○
hair loss	○	○
heat or cold intolerance	○	○

Allergic/Immunologic

○ None

	Yes	No
HIV exposure	○	○
immunodeficiency disorder	○	○
urticaria/hives	○	○

	Yes	No
pain in rectum	○	○
incontinence of stools	○	○
change in bowel habits	○	○

Hematologic/Lymphatic	Yes	No
○ None		
bleeds easily	○	○
bruises easily	○	○
swollen lymph nods in neck, armpits, groin	○	○

Pharmacy

Name: _____

Reviewed with

○ Patient ○ Parent ○ Guardian ○ Not Present

Signature

_____

Signature Date