CURRENT SYMPTOMS ONLY

(Please circle)

Review Of Systems

Gastrointestinal
None
abdominal pain
belching
black stool
bloating
blood in stool
change in bowel habits
constipation
diarrhea
hemorrhoids
indigestion/ heartburn
jaundice/ yellowing of the skin
nausea
nocturnal symptoms
rectal bleeding
fecal soiling/incontience
thin caliber sized stool
trouble swallowing
vomiting
excessive gassiness

Constitutional
None
able to eat only small amounts
fatigue
fever/ chills
loss of appetite
sweats
weight gain
weight loss

Cardiovascular
None
abnormal EKG
chest pain
palpitations
passing out/ fainting
shortness of breath
swelling in hands, legs or feet

Respiratory
None
cough
coughing up blood
shortness of breath with exercise
wheezing

ENMT
None
hoarseness
nasal obstruction
nose bleeds
poor vision, change in vision

Endocrine
None
excessive thirst
heat intolerance

Genitourinary
None
blood in urine
dark urine
pain or burning with urination
sexually transmitted disease
kidney stones
kidney infections

Hematologic/Lymphatic
None
easy / frequent bruising

Integumentary
None
itching
rashes

Musculoskeletal
None
back pain
joint pain
swollen joints

Neurological
None
dizziness/ lightheadedness
fainting
frequent headaches
memory loss

Psychiatric
None
anxiety
depression
confusion
panic attacks

Patient Name: _____

Date of Birth: _____

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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

☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law

Sex

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ Patient declines to specify

Contact Preference

☐ Patient Portal ☐ E-mail ☐ Telephone call ☐ Patient declines to specify

Pharmacy

Name Address Phone

Allergies

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

☐ Codeine Sulfate ☐ Penicillins ☐ Latex ☐ Seafood ☐ Soy and Egg

☐ Iodine And Iodide Containing Products ☐ Sulfa (Sulfonamide Antibiotics) Other: _____ Other: _____

Immunizations

☐ None

☐ Flu vaccine When: _____ ☐ Hep A, adult When: _____ ☐ Hep B, adult When: _____ ☐ Pneumonia When: _____

Current Medications

☐ None

Name	Dose	How taken?

Diagnostic Studies/Tests

- [ ] None

- [ ] Blood tests within last 6 months — When:_____
- [ ] Colonoscopy — When:_____
- [ ] Endoscopy (EGD) — When:_____
- [ ] CT Scan Abdomen/Pelvis — When:_____
- [ ] Ultrasound Abdomen or Pelvis — When:_____

Previous Procedures

- [ ] None

- [ ] Abdominal Exploratory Surgery
- [ ] Appendectomy
- [ ] Back Surgery
- [ ] Breast
- [ ] Cardiac Surgery (specify)
- [ ] C-Section
- [ ] Colon Resection
- [ ] Gallbladder Surgery
- [ ] Gastric Bypass - specify type
- [ ] Groin Surgery
- [ ] Hemorrhoid Banding/Surgery
- [ ] Hiatal Hernia Repair (fundoplication)
- [ ] Hernia Repair (specify area)
- [ ] Hysterectomy
- [ ] Joint Replacement - specify site
- [ ] Ovary
- [ ] Stomach
- [ ] Tonsillectomy
- [ ] Tubal Ligation
- Other:_____

Past or Present Medical Conditions

- [ ] None

Gastrointestinal:

- [ ] Barrett's Esophagus
- [ ] Celiac Disease
- [ ] Cirrhosis
- [ ] Colitis, Ulcerative
- [ ] Colon Cancer
- [ ] Colon Polyps
- [ ] Crohn's Disease
- [ ] Diverticulosis, Diverticulitis
- [ ] Fatty Liver
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] Hiatal hernia
- [ ] IBS
- [ ] Pancreatitis
- [ ] Stomach Ulcer
- [ ] Reflux

Heart:

- [ ] Atrial Fibrillation
- [ ] Coronary Artery Disease
- [ ] Congestive Heart Failure
- [ ] Heart Murmur
- [ ] Heart Surgery or Stent
- [ ] Heart Valve Disease/Repair
- [ ] MI (Heart Attack)
- [ ] High blood pressure
- [ ] Implanted Defibrillator
- [ ] Irregular Heart Beat
- [ ] Pacemaker

Lung:

- [ ] Asthma
- [ ] Blood Clot (Lung)
- [ ] Emphysema/ COPD
- [ ] History of lung surgery
- [ ] Oxygen use
- [ ] Pneumonia
- [ ] Sleep apnea

Other Medical Conditions:

- [ ] Anemia
- [ ] Arthritis
- [ ] Anxiety
- [ ] Blood Clot (Leg)
- [ ] Blood transfusion
- [ ] Body Piercing
- [ ] Breast Cancer
- [ ] Cataracts
- [ ] Depression
- [ ] Diabetes, Oral Meds
- [ ] Diabetes Mellitus, Insulin Dependent
- [ ] Eosinophilic esophagitis
- [ ] Fibromyalgia
- [ ] Gallstones
- [ ] Glaucoma
- [ ] Gout
- [ ] High Cholesterol
- [ ] History of a CVA (stroke, TIA)
- [ ] HIV/ Aids
- [ ] Kidney Disease
- [ ] Lactose Intolerance
- [ ] Lung Cancer
- [ ] Mental disorder
- [ ] Migraine Headaches
- [ ] Multiple Sclerosis
- [ ] Ovarian Cancer
- [ ] Prostate Cancer
- [ ] Seizures
- [ ] Skin Cancer
- [ ] Tattoos
- [ ] TB (Tuberculosis)
- [ ] Thyroid Disorder

Social History

Occupation: _____ Number of Children: _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Alcohol

☐ None

	Type	Quantity	Number	Frequency
☐	Past			
☐	Current			

Caffeine

☐ None

☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink ☐ Other (Specify)

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
☐	Chewing Tobacco				

Drug Use

☐ None

	Type	Frequency
☐	Use Recreational Drugs Now	
☐	Used IV Drugs in the Past	
☐	Used Other Drugs in the Past	

Family Medical History

☐ No knowledge of family history

No family history of ☐ Colon Cancer ☐ Colon Polyp

Health Status	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather
	○	○	○	○	○	○	○	○
Deceased/At Age	____	____	____	____	____	____	____	____
Diagnoses								
Colon Cancer	○	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○	○
Alcoholism	○	○	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○	○	○
colitis	○	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○	○	○
Hypertension	○	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○	○
Malignancy	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○
Stroke	○	○	○	○	○	○	○	○
Thyroid Disease	○	○	○	○	○	○	○	○

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 for continuity of care. (ex. your primary care provider)

☐ Yes ☐ No

Reminder Preference

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

☐ Yes ☐ No

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present