

**PATIENT INTERVIEW**

Patient First Name \_\_\_\_\_

Patient Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Email \_\_\_\_\_

**Race** (Select one or more)

- |                                  |  |  |
|----------------------------------|--|--|
| <input type="checkbox"/> White   | <input type="checkbox"/> Black or African American   | <input type="checkbox"/> American Indian or Alaska Native          |
| <input type="checkbox"/> Asian   | <input type="checkbox"/> Patient declines to specify | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Other                       |  |

**Ethnicity**

- |   |   |  |                                  |
|---|---|--|----------------------------------|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Patient declines to specify | <input type="checkbox"/> Unknown |
|---|---|--|----------------------------------|

**Gender**

- |                               |                                 |                                |
|-------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Other |
|-------------------------------|---------------------------------|--------------------------------|

**Preferred Language**

- |   |                                  |  |                                  |  |
|---|----------------------------------|--|----------------------------------|--|
| <input type="checkbox"/> Chinese            | <input type="checkbox"/> English | <input type="checkbox"/> Central Khmer | <input type="checkbox"/> Korean  | <input type="checkbox"/> Patient declines to specify |
| <input type="checkbox"/> Spanish; Castilian | <input type="checkbox"/> Tagalog | <input type="checkbox"/> Vietnamese    | <input type="checkbox"/> Russian |  |

**Contact Preference**

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> Home Phone                     | <input type="checkbox"/> Mobile Phone | <input type="checkbox"/> Patient Portal              |
| <input type="checkbox"/> All preferences are acceptable | <input type="checkbox"/> Letter       | <input type="checkbox"/> Patient declines to specify |

**Allergies**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Patient has no known allergies                    | <input type="checkbox"/> Patient has no known drug allergies | <input type="checkbox"/> Nickel<br>Reaction _____   |
| <input type="checkbox"/> Eggs<br>Reaction _____                            | <input type="checkbox"/> Latex<br>Reaction _____             | <input type="checkbox"/> Soy<br>Reaction _____  |
| <input type="checkbox"/> Aspirin<br>Reaction _____                         | <input type="checkbox"/> IV Contrast<br>Reaction _____       | <input type="checkbox"/> Penicillins<br>Reaction _____                                    |
| <input type="checkbox"/> Sulfa (Sulfonamide Antibiotics)<br>Reaction _____ | <input type="checkbox"/> Peanuts<br>Reaction _____           | <input type="checkbox"/> Surgical tape<br>Reaction _____                                  |
| Other _____  | Reaction _____   | <input type="checkbox"/> NSAIDS (Non-steroidal anti-inflammatory drugs)<br>Reaction _____ |

**Pharmacy**

Name

Address

Phone

**Consent to Import Medication History**

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

- Yes  No

**Current Medications**

None

Medication Name	Dose	How many times per day?

**Immunizations**

None

Hepatitis A

When \_\_\_\_\_

Hepatitis B

When \_\_\_\_\_

Flu Vaccine

When \_\_\_\_\_

Pneumococcal

When \_\_\_\_\_

**Diagnostic Studies/Tests**

None

Colonoscopy

When \_\_\_\_\_

EGD (Upper Endoscopy)

When \_\_\_\_\_

ERCP (Endoscopic exam of the bile ducts)

When \_\_\_\_\_

Flexible Sigmoidoscopy

When \_\_\_\_\_

Capsule Endoscopy

When \_\_\_\_\_

Barium Enema

When \_\_\_\_\_

CT Scan - Abdomen/Pelvis

When \_\_\_\_\_

Endoscopic Ultrasound - Lower (EUS)

When \_\_\_\_\_

Endoscopic Ultrasound - Upper (EUS)

When \_\_\_\_\_

Esophagram

When \_\_\_\_\_

HIDA Scan

When \_\_\_\_\_

Liver Biopsy

When \_\_\_\_\_

MRI - Abdomen/Pelvis

When \_\_\_\_\_

Ultrasound - Abdomen

When \_\_\_\_\_

## Past or Present Medical Conditions

None

### General

Does not accept blood products

Blood thinner (other than aspirin)

Defibrillator

Pacemaker

Home oxygen

Other \_\_\_\_\_

### Cardiovascular

Abdominal Aortic Anuerysm

Atrial fibrillation

Congestive heart failure

Coronary artery disease

Heart attack

Heart valve disorder

High cholesterol

Hyperlipidemia

Hypertension

Peripheral vascular disease

Other \_\_\_\_\_

### Endocrine

Type 1 diabetes mellitus

Type 2 diabetes mellitus

Thyroid disease

Other \_\_\_\_\_

### Gastrointestinal

Barrett's esophagus

Colon cancer

Colon polyps

Celiac disease / Sprue

Cirrhosis

Crohn's disease

Diverticulitis

Fatty liver

Gallstones

Gastroparesis

Gastric ulcer

GERD (gastroesophageal reflux disease)

H. Pylori Infection

Hepatitis A

Hepatitis B

Hepatitis C

Irritable bowel syndrome

Pancreatitis

Ulcer disease

Ulcerative colitis

Other \_\_\_\_\_

### Neurological

Seizure disorder

Stroke

TIA (mini-stroke)

Other \_\_\_\_\_

### Pulmonary

Asthma

Chronic bronchitis

COPD

Emphysema

Pulmonary embolism (blood clot-lung)

Sleep apnea

Other \_\_\_\_\_

### Other

Anemia

Arthritis

Bipolar disorder

Breast cancer

Chronic kidney disease

Depression

DVT (deep vein thrombosis)

Fibromyalgia

HIV/AIDS

Kidney stones

Liver cancer

Lung cancer

Osteoporosis

Ovarian cancer

Pancreatic cancer

Prostate cancer

Rheumatoid arthritis

Skin cancer

Uterine cancer

Other \_\_\_\_\_

## Previous Procedures

None

Abdominal Aortic Anuerysm (AAA) repair

Appendectomy

Blood transfusion (prior to 1992)

C-section

Cholecystectomy (gallbladder removal)

Colon resection

Coronary artery bypass grafting (CABG)

Exploratory abdominal surgery

Gastric pacemaker

Heart stent

Heart valve replacement/surgery

Hemorrhoid surgery

Hernia repair (abdominal)

Hernia repair (hiatal)

Hysterectomy

Implanted medical device

Lap band surgery

Liver biopsy

Lung resection

Pancreas surgery

Reflux surgery

Small bowel resection

Weight loss surgery (bariatric)

Other \_\_\_\_\_

**Social History**

Occupation \_\_\_\_\_

**Marital Status**

- Single       Married       Divorced       Separated       Widowed       Civil Union

Other \_\_\_\_\_

**Alcohol**

- None       Occasional       Social       Moderate       Heavy       Recovering alcoholic

**Caffeine**

None      Intake \_\_\_\_\_

**Tobacco (Smoking Status)**

- Current, every day smoker       Current some days smoker       Former smoker       Never smoked  
 Smoker, current status unknown       Light tobacco smoker       Heavy tobacco smoker       Unknown if ever smoked  
 Chewing Tobacco       Smokeless

**Drug Use**

- None       History of IV drug use       Current recreational drug use       Former recreational drug use       Current use of marijuana

**Family Medical History**

- No knowledge of family history      No family history of:       Colon cancer       Colon polyps  
 Crohn's disease       Liver disease  
 Ulcerative colitis

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Other
Colon cancer							
Colon polyps							
Crohn's disease							
Liver disease							
Ulcerative colitis							

**Review of Systems**

**Cardiovascular**

- None      Y    N  
Chest pain           
Irregular heart beat           
Swelling of legs or feet

**Constitutional**

- None      Y    N  
Fatigue           
Fever           
Weight gain           
Weight loss

**Ear Nose Mouth Throat**

- None      Y    N  
Difficulty swallowing           
Sore throat           
Hearing loss

**Endocrine**

- None      Y    N  
Excessive thirst           
Heat intolerance

**Gastrointestinal**

- None      Y    N  
Abdominal pain           
Constipation           
Diarrhea           
Gas           
Heartburn           
Nausea           
Rectal bleeding           
Vomiting           
Rectal pain           
Vomiting of blood           
Black stools           
Leakage of stool

**Hematologic/Lymphatic**

- None      Y    N  
Easy bruising           
Enlarged/swollen glands

**Integumentary**

- None      Y    N  
Itching           
Yellow skin or eyes           
Rashes

**Musculoskeletal**

- None      Y    N  
Back pain           
Joint pain           
Muscle weakness

**Psychiatric**

- None      Y    N  
Anxiety           
Depression

**Respiratory**

- None      Y    N  
Cough           
Wheezing           
Coughing up sputum           
Dyspnea (shortness of breath)           
Hemoptysis (coughing up blood)

**Office Use Only**

Reviewed with       Patient       Parent       Guardian       Not Present