Patient Interview Form

Patient Information

First Name:____________________ Last Name:____________________
MRN:____________________ Date Of Birth:____________________
Age:____________________

Email

Please check one as your preferred email for communications

- ☐ Personal:____________________
- ☐ Work:____________________

Ethnicity

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

Race

Select one or more

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race
- ☐ Unknown
- ☐ Patient declines to specify
- ☐ Prohibited by state law

Preferred Language

- ☐ English
- ☐ Korean
- ☐ Spanish; Castilian
- ☐ Patient declines to specify

Contact Preference

- ☐ Telephone call
- ☐ Portal
- ☐ Patient declines to specify
- Other:____________

Allergies

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

Food

- ☐ Eggs
- ☐ Nuts
- ☐ Shellfish

● **Medication**

- Glaucoma
- Heart attack
- High blood pressure
- High cholesterol
- HIV
- Kidney disease
- Lupus
- Osteopenia
- Osteoporosis
- Seizure disorder
- Sleep apnea
- Stroke/TIA
- Thyroid, overactive
- Thyroid, underactive

Other: ____________

Supplements -if using the patient portal, please enter through the medication section instead.

- Please list vitamins: ____________
- Please list herbal supplements: ____________
- Please list dietary supplements: ____________

Previous Gastroenterology Procedures

- None
- Colonoscopy
- EGD/Upper endoscopy
- ERCP
- Endoscopic ultrasound/EUS
- Small bowel capsule
- Liver biopsy

Other: ____________

Surgical Procedures

- None
- Appendectomy
- C-Section
- Cataract surgery
- Colon resection
- Coronary artery bypass
- Coronary/Stent
- Defibrillator
- Gallbladder removed
- Gastric bypass
- Heart valve replacement/repair
- Hemorrhoidectomy
- Hiatal hernia surgery (for reflux)
- Hysterectomy, partial (ovaries intact)
- Hysterectomy, total (ovaries removed)
- Inguinal hernia surgery (groin)
- Joint surgery / replacement
- Lap band
- Liver transplant
- Mastectomy
- Pacemaker
- Prostatectomy
- Tonsillectomy
- Tubal ligation
- Ulcer surgery
- Umbilical hernia surgery (belly-button)

Other: ____________

Social History

Occupation: ____________

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed
- Other

Alcohol

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

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

Review Of Systems

Gastrointestinal

☐ None

	Y	N
abdominal pain	○	○
anorectal pain/itching	○	○
black tarry stools	○	○
bloating/gas	○	○
blood in stool	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
stool incontinence (leakage)	○	○
heartburn/reflux	○	○
difficulty swallowing	○	○
nausea	○	○
vomiting	○	○

Genitourinary

☐ None

	Y	N
blood in urine	○	○
dark urine	○	○
heavy menstruation	○	○
pregnancy	○	○
frequent urination	○	○

Integumentary

☐ None

	Y	N
itching	○	○
jaundice	○	○
rashes	○	○

Cardiovascular

☐ None

	Y	N
heart murmur	○	○
irregular heart beat	○	○
hand/ankle swelling	○	○
rapid heart rate/palpitations	○	○
shortness of breath	○	○
chest pain	○	○

Neurological

☐ None

	Y	N
frequent headaches	○	○
memory loss/confusion	○	○
numbness or tingling	○	○

Endocrine

☐ None

	Y	N
cold intolerance	○	○
excessive thirst	○	○

Constitutional

☐ None

	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
night sweats	○	○
weight gain	○	○
weight loss	○	○

Psychiatric

☐ None

	Y	N
anxiety	○	○
depression	○	○

ENMT

☐ None

	Y	N
double vision	○	○
eye irritation	○	○
eye pain	○	○
eye redness	○	○
sore throat	○	○
hoarseness	○	○
mouth sores	○	○

Hematologic/Lymphatic

☐ None

	Y	N
easy bruising	○	○
prolonged bleeding	○	○

Musculoskeletal

☐ None

	Y	N
back pain	○	○
joint pain	○	○

Respiratory

☐ None

	Y	N
frequent cough	○	○
snoring	○	○
sleep apnea	○	○
wheezing	○	○

Allergic/Immunologic

☐ None

	Y	N
allergies	○	○

Consent to Import Medication History

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

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

☐ Yes ☐ No

Reminder Preference