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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

- Letter
- Email
- Patient Portal
- Telephone call
- Cell
- Patient declines to specify

Other:____________

Allergies

- Patient has no known allergies
- Patient has no known drug allergies
- Codeine
- Demerol
- Latex
- Penicillin
- Tape
- Propofol
- Cipro
- Aspirin
- Sulfa
- Morphine (PF)
- Novocaine
- Versed
- iodine
- Sulfasalazine

Other:____________

Social History

Occupation:______________________ Number of Children:______________________

Marital Status

- ⬭ Single
- ⬭ Married
- ⬭ Divorced
- ⬭ Separated
- ⬭ Widowed
- ⬭ Civil Union
- ⬭ Unknown
- ⬭ Other

Alcohol

⬭ None

Type	Quantity	Number	Frequency
⬭ Rarely			
⬭ Daily			
⬭ More than 2days/week			
⬭ Less than 2 days/week			
⬭ I quit using alcohol			

Caffeine

⬭ None

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
⬭ Cigarettes				
⬭ Cigar				
⬭ Smokeless				
⬭ Other				

Drug Use

⬭ None

Type	Quantity	Number	Frequency
⬭ I use illicit drugs			
⬭ I quit using illicit drugs			
⬭ I have never used illicit drugs			
⬭ Injection drug use			

Exercise

⬭ None

Type	Quantity	Number	Frequency
⬭ Type of Exercise			

Immunizations

⬭ None

- ⬭ Hep A When:__________
- ⬭ Hep B When:__________
- ⬭ Pneumonia When:__________
- ⬭ Shingles When:__________
- ⬭ Tdap When:__________

Diagnostic Studies/Tests

⬭ None

- ⬭ Colonoscopy When:__________
- ⬭ Egd When:__________
- ⬭ EKG When:__________

Past or Present Medical Conditions

- ◯ None

- ◯ Anemia When:______
- ◯ Cirrhosis of Liver When:______
- ◯ Colitis When:______
- ◯ Colon cancer When:______
- ◯ Colon polyps When:______
- ◯ Crohn's Disease When:______
- ◯ Diarrhea When:______
- ◯ Diabetes When:______
- ◯ Diverticulitis When:______
- ◯ Diverticulosis When:______
- ◯ Duodenal Ulcer When:______
- ◯ Fatty Liver When:______
- ◯ Gallstones When:______
- ◯ Hepatitis A When:______
- ◯ Hepatitis B When:______
- ◯ Hepatitis C When:______
- ◯ Hiatal Hernia When:______
- ◯ IBS When:______
- ◯ Lactose Intolerance When:______
- ◯ Pancreatitis When:______
- ◯ Stomach Ulcer When:______
- ◯ Ulcerative Colitis When:______
- ◯ Asthma When:______
- ◯ Atrial Fibrilation When:______
- ◯ Back Pain (chronic) When:______
- ◯ Breast Cancer When:______
- ◯ Cancer When:______
- ◯ Chronic Lung Disease When:______
- ◯ Congestive Heart Failure When:______
- ◯ Depression/ Anxiety When:______
- ◯ Emphysema When:______
- ◯ Frequent Urinary Tract Infections When:______
- ◯ Glaucoma When:______
- ◯ Heart Attack When:______
- ◯ Heart Murmur When:______
- ◯ High Blood Pressure When:______
- ◯ High Cholesterol When:______
- ◯ High Triglycerides When:______
- ◯ History of Suicide Attempts When:______
- ◯ HIV/AIDS When:______
- ◯ Irregular Heart Beat When:______
- ◯ Kidney Disease When:______
- ◯ Kidney Failure When:______
- ◯ Kidney Stones When:______
- ◯ Lupus When:______
- ◯ Migraines When:______
- ◯ Osteoarthritis When:______
- ◯ Paralysis When:______
- ◯ Parkinsons When:______
- ◯ Pneumonia When:______
- ◯ Rheumatoid arthritis When:______
- ◯ Seizures When:______
- ◯ Skin Cancer When:______
- ◯ Sleep apnea When:______
- ◯ Stroke When:______
- ◯ TB (Tuberculosis) When:______
- ◯ TB skin Test Positive When:______
- ◯ Thyroid disease When:______
- ◯ Uterine Cancer When:______
- ◯ Reflux When:______

Previous Procedures

- ◯ None

- ◯ ERCP When:______
- ◯ Liver Biopsy When:______
- ◯ Sigmoidoscopy When:______
- ◯ Appendectomy When:______
- ◯ Breast When:______
- ◯ C-Section When:______
- ◯ Cardiac Surgery When:______
- ◯ Colon Resection When:______
- ◯ Gallbladder Surgery When:______
- ◯ Heart Bypass Surgery When:______
- ◯ Heart Stent When:______
- ◯ Heart Valve Replacement When:______
- ◯ Hemorrhoids When:______
- ◯ Hiatal Hernia When:______
- ◯ Hysterectomy When:______
- ◯ Joint Surgery/Replacement When:______
- ◯ Kidney When:______
- ◯ Obesity Surgery When:______
- ◯ Prostate When:______
- ◯ Stomach When:______
- ◯ Thyroid When:______
- ◯ Transplant Surgery When:______
- ◯ Defibrillator When:______
- ◯ Pacemaker When:______

Family Medical History

○ No knowledge of family history

No family history of ○ Colon cancer ○ Polyps

Health Status	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Paternal Grandmother
Age/Date of Birth	___	___	___	___	___	___	___	___
Healthy	○	○	○	○	○	○	○	○
Ill	○	○	○	○	○	○	○	○
Seriously Ill	○	○	○	○	○	○	○	○
Disabled	○	○	○	○	○	○	○	○
In Remission	○	○	○	○	○	○	○	○
Alive	○	○	○	○	○	○	○	○
Deceased/At Age	○ ___	○ ___	○ ___	○ ___	○ ___	○ ___	○ ___	○ ___
Cause of Death	___	___	___	___	___	___	___	___
Diagnoses								
Crohn's Disease	○	○	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○	○	○
Pancreas Cancer	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○	○
Ovarian Cancer	○	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○	○
Colon Polyp	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○

Health Status	Maternal Grandfather	Paternal Grandfather	Maternal Aunt	Paternal Aunt	Maternal Uncle	Paternal Uncle
Age/Date of Birth	___	___	___	___	___	___
Healthy	○	○	○	○	○	○
Ill	○	○	○	○	○	○
Seriously Ill	○	○	○	○	○	○
Disabled	○	○	○	○	○	○
In Remission	○	○	○	○	○	○
Alive	○	○	○	○	○	○
Deceased/At Age	○ ___	○ ___	○ ___	○ ___	○ ___	○ ___
Cause of Death	___	___	___	___	___	___
Diagnoses						
Crohn's Disease	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○
Pancreas Cancer	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○
Ovarian Cancer	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Colon Polyp	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Current Medications

⬭ None

Name | Dose | How taken?

Pharmacy

Name | Address | Phone

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 my insurance company, pharmacy and other physicians involved in my care.

⬭ Yes ⬭ No