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Patient Interview Form

Patient Information

First Name:______________________ Last Name:______________________

MRN:______________________ Date Of Birth:______________________

Age:______________________ Notes:______________________

Email
Please check one as your preferred email for communications

- ⬭ Personal:______________________
- ⬭ Work:______________________

Sex

- ⬭ Male
- ⬭ Female
- ⬭ Other

Allergies

- ⬭ Patient has no known allergies
- ⬭ Patient has no known drug allergies

- ⬭ Penicillins
- ⬭ Sulfa (Sulfonamide Antibiotics)
- ⬭ codeine-guaifenesin
- ⬭ morphine
- ⬭ Shellfish
- ⬭ Latex

Other:____________

Pharmacy

____

Name Address Phone

Current Medications

- ⬭ None

Name	Dose	How taken?

Diagnostic Studies/Tests

- ☐ None

- ☐ Colonoscopy When:______________
- ☐ Endoscopy When:______________
- ☐ Abdominal Ultrasound When:______________
- ☐ CT Abdomen/Pelvis When:______________
- ☐ MRI Abdomen When:______________
- ☐ Blood Work When:______________

Previous Procedures

- ☐ None

- ☐ Appendectomy When:______________
- ☐ Caeserean Section When:______________
- ☐ Cholecystectomy (gallbladder removal) When:______________
- ☐ Hysterectomy When:______________
- ☐ Hernia Repair When:______________

Other:______________

Social History

Occupation:____ Number of Children:________________________________

Marital Status

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

Alcohol

- ☐ None

- ☐ Daily
- ☐ More than 7 per week
- ☐ Less than 7 per week
- ☐ Socially
- ☐ Occasional

Caffeine

- ☐ None

- ☐ Coffee or Tea
- ☐ Other

Intake:____________________________________

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

Drug Use

- ☐ None

- ☐ Uses IV drugs currently
- ☐ Used IV drugs in the past
- ☐ Recreational drug use

Past or Present Medical Conditions

- [ ] None

Cardiovascular	High blood pressure	Coronary Heart Disease	Myocardial infarction	Serum cholesterol abnormal
Endocrine	Diabetes Mellitus	Hypothyroidism		
Gastrointestinal	Colon Polyps	Acid Reflux		
Pulmonary	Asthma	COPD		
Other	Anemia	Arthritis	Other: ________	

Review Of Systems

Constitutional

None	Y	N
fatigue	○	○
weight loss	○	○
fever	○	○

Gastrointestinal

None	Y	N
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas or bloating	○	○
heartburn	○	○
nausea	○	○
vomiting	○	○
rectal bleeding	○	○
black stool	○	○
difficulty swallowing	○	○
loss of appetite	○	○
rectal pain	○	○
lactose intolerance	○	○
fecal incontinence	○	○

Allergic/Immunologic

None	Y	N
food Allergies	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

None	Y	N
chest pain	○	○
palpitations	○	○

ENMT

None	Y	N
difficulty swallowing	○	○
chronic cough	○	○
sore throat or voice change	○	○

Endocrine

None	Y	N
excessive thirst or urination	○	○
heat or cold intolerance	○	○

Eyes

None	Y	N
blurred or double vision	○	○
loss of vision	○	○

Genitourinary

None	Y	N
dysuria	○	○
frequent urination	○	○

Hematologic/Lymphatic

None	Y	N
anemia	○	○
easy bruising	○	○
prolonged bleeding	○	○

Integumentary

None	Y	N
allergies	○	○
itching	○	○
jaundice	○	○

Musculoskeletal

None	Y	N
arthritis	○	○
back pain	○	○

Neurological

None	Y	N
dizziness	○	○
seizures or convulsions	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○

Respiratory

None	Y	N
asthma	○	○
cough	○	○
dyspnea	○	○

Family Medical History

No knowledge of family history

No family history of Colon Cancer | Colon Polyps

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Other
Colon Polyps							
Colon Cancer							
Liver Cancer							
Liver Disease							
Pancreatic Cancer							
Ulcerative Colitis							
Crohn's Disease							
Celiac Disease							
Gynecological Cancer- specify							
Other:							

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities with whom I am being treated or with whom I have a future appointment.

Yes No

Signature

Signature Date