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OF THE SOUTHEAST

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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Email

Personal:_____

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

Ethnicity

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

Sex

- ☐ Male
- ☐ Female
- ☐ Other

Preferred Language

- ☐ English
- ☐ Patient declines to specify

Contact Preference

- ☐ Letter
- ☐ Telephone call
- ☐ e-mail
- ☐ Cell Phone
- ☐ Patient declines to specify

Other:_____

Reminder Preference

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

- ☐ Yes
- ☐ No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

☐ Yes ☐ No

Allergies

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

☐ Demerol ☐ IVP Dye ☐ Penicillins ☐ Propofol ☐ Codeine Sulfate

☐ Lortab ☐ Ambien ☐ Latex ☐ Versed ☐ Sulfa (Sulfonamide Antibiotics)

Other:_____ Other:_____

Immunizations

☐ None

☐ Flu Vaccine When:_____ ☐ Hep B When:_____ ☐ PPD/TB Skin Test When:_____ ☐ Pneumonia Vaccine When:_____

Pharmacy

Name Address Phone

Consent to Import Medication History

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

☐ Yes ☐ No

Current Medications

☐ None

Name	Dose	How taken?

Diagnostic Studies/Tests

☐ None

☐ Abdominal Ultrasound When:_____
☐ Barium Swallow When:_____
☐ Colonoscopy When:_____
☐ CT Abdomen When:_____
☐ HIDA Scan When:_____
☐ Sigmoidoscopy When:_____
☐ Test for Blood in Stool When:_____
☐ Upper Endoscopy/EGD When:_____
☐ Esophageal Motility Study When:_____
Other:_____

Previous Procedures

☐ None

☐ Appendectomy/Appendix When:_____
☐ Cholecystectomy/Gallbladder When:_____
☐ Colon Surgery When:_____
☐ Defibrillator When:_____
☐ Gastric Bypass When:_____
☐ Heart Bypass When:_____
☐ Heart Valve Replacement When:_____
☐ Hemorrhoid Surgery When:_____
☐ Hernia Repair When:_____
☐ Hysterectomy When:_____
☐ Pacemaker When:_____
☐ Paracentesis When:_____
☐ Prostate Surgery When:_____
Other:_____
Other:_____

Past or Present Medical Conditions

☐ None

☐ Anemia
☐ Anxiety/Depression
☐ Arthritis
☐ Atrial Fibrillation
☐ Barrett's Esophagus
☐ Bleeding Disorders
☐ Blood Clots (DVT)
☐ Cancer
☐ Celiac Disease
☐ Cirrhosis
☐ Colon Polyps
☐ Congestive Heart Failure
☐ Crohn's Disease
☐ Diabetes (Insulin Dependent)
☐ Diabetes (Non Insulin Dependent)
☐ Diverticulitis/Diverticulosis
☐ Gallstones
☐ GERD or reflux disease
☐ GI Bleeding
☐ Heart Attack
☐ Hemorrhoids
☐ Hepatitis C
☐ High Blood Pressure
☐ HIV
☐ Irritable Bowel Syndrome
☐ Kidney Dialysis
☐ Liver Disease
☐ Pancreatitis
☐ Pulmonary Embolism
☐ Seizure Disorder
☐ Stroke
☐ Ulcer Disease
☐ Ulcerative Colitis
Other:_____
Other:_____

Social History

Occupation:_____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Alcohol

☐ None

Type Quantity Number Frequency

_____

Caffeine

☐ None

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

Type	Quantity	Number	Frequency

Exercise

◯ None

Type	Quantity	Number	Frequency

Review Of Systems

Constitutional

◯ None	Y	N
chronic fatigue	◯	◯
fever	◯	◯
weight loss	◯	◯

Integumentary

◯ None	Y	N
bruising	◯	◯
rash	◯	◯

Hematologic/Lymphatic

◯ None	Y	N
anemia	◯	◯
blood disorders	◯	◯
easy bleeding	◯	◯

Musculoskeletal

◯ None	Y	N
weakness	◯	◯
back pain	◯	◯
joint pain	◯	◯

ENMT

◯ None	Y	N
deafness	◯	◯
dizziness	◯	◯
mouth or throat sores	◯	◯
hoarseness	◯	◯

Respiratory

◯ None	Y	N
asthma	◯	◯
wheezing	◯	◯
cough	◯	◯
shortness of breath	◯	◯

Cardiovascular

◯ None	Y	N
chest pain	◯	◯
palpitations	◯	◯

Gastrointestinal

◯ None	Y	N
diarrhea	◯	◯
constipation	◯	◯
heartburn	◯	◯
stomach cramps	◯	◯
nausea	◯	◯
vomiting	◯	◯
blood in stool	◯	◯
blood on the tissue paper	◯	◯
bloating	◯	◯
jaundice	◯	◯
gas	◯	◯
trouble swallowing	◯	◯
abdominal pain	◯	◯

Genitourinary

◯ None	Y	N
increased urinary frequency	◯	◯
change in urine color	◯	◯
prostate problems	◯	◯

Neurological

◯ None	Y	N
stroke	◯	◯
numbness	◯	◯

Psychiatric

◯ None	Y	N
bad nerves	◯	◯
depression	◯	◯

Family Medical History

No knowledge of family history

No family history of Colon Polyps

Health Status	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Maternal Grandfather
Cause of Death								
Diagnoses								
Gallstones	○	○	○	○	○	○	○	○
Pancreas problems	○	○	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○	○	○
Stomach ulcers	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○

Health Status	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	First Cousin
Cause of Death					
Diagnoses					
Gallstones	○	○	○	○	○
Pancreas problems	○	○	○	○	○
Liver disease	○	○	○	○	○
Colon polyps	○	○	○	○	○
Colon cancer	○	○	○	○	○
Crohn's disease	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○
Stomach ulcers	○	○	○	○	○
Other:	○	○	○	○	○