

## Patient Interview Form

### Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

#### Race

- White/Caucasian   
  Black or African American   
  Asian   
  Hispanic or Latino   
  American Indian or Alaska Native  
 Native Hawaiian or Other Pacific Islander   
  Mixed   
  Other   
  Unknown   
  Patient declines to provide information  
 Prohibited by state law

#### Ethnicity

- Hispanic or Latino   
  Not Hispanic or Latino   
  Patient declines to provide information   
  Prohibited by state law

#### Preferred Language

- English   
 Other: \_\_\_\_\_

#### Contact Preference

Other: \_\_\_\_\_

#### Allergies

- Patient has no known allergies   
  Patient has no known drug allergies  
 Latex   
  eggs   
 Other: \_\_\_\_\_

#### Immunizations

- None  
 Hep B   
  Hep A   
  PPD   
 Other: \_\_\_\_\_  
 When: \_\_\_\_\_   
 When: \_\_\_\_\_   
 When: \_\_\_\_\_

#### Diagnostic Studies/Tests

- None  
 Colonoscopy   
  Endoscopy   
  ERCP   
  CT Scan   
  Sonogram  
 When: \_\_\_\_\_   
 When: \_\_\_\_\_   
 When: \_\_\_\_\_   
 When: \_\_\_\_\_   
 When: \_\_\_\_\_  
 MRI   
  Blood Tests  
 When: \_\_\_\_\_   
 When: \_\_\_\_\_

#### Previous Procedures

- None

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Appendectomy<br>When: _____      | <input type="checkbox"/> Cardiac Stents<br>When: _____      | <input type="checkbox"/> Cataracts<br>When: _____      | <input type="checkbox"/> Colon Resection<br>When: _____ | <input type="checkbox"/> C-Section<br>When: _____           |
| <input type="checkbox"/> Joint replacement<br>When: _____ | <input type="checkbox"/> Gallbladder removed<br>When: _____ | <input type="checkbox"/> Heart Surgery<br>When: _____  | <input type="checkbox"/> Hernia Repair<br>When: _____   | <input type="checkbox"/> Hysterectomy<br>When: _____        |
|   | <input type="checkbox"/> Tonsillectomy<br>When: _____       | <input type="checkbox"/> Tubal Ligation<br>When: _____ | <input type="checkbox"/> Vasectomy<br>When: _____       | <input type="checkbox"/> Weight Loss Surgery<br>When: _____ |

**Past or Present Medical Conditions**

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> None                                     |  |  |  |   |
| <input type="checkbox"/> Anemia<br>When: _____                    | <input type="checkbox"/> Anxiety disorder<br>When: _____     | <input type="checkbox"/> Arthritis<br>When: _____                | <input type="checkbox"/> Asthma<br>When: _____                 | <input type="checkbox"/> Barrett's Esophagus<br>When: _____ |
| <input type="checkbox"/> Breast cancer<br>When: _____             | <input type="checkbox"/> Celiac Sprue<br>When: _____         | <input type="checkbox"/> Chest Pain<br>When: _____               | <input type="checkbox"/> Cirrhosis<br>When: _____              | <input type="checkbox"/> Colon cancer<br>When: _____        |
| <input type="checkbox"/> Colon polyps<br>When: _____              | <input type="checkbox"/> C.O.P.D.<br>When: _____             | <input type="checkbox"/> Crohn's Disease<br>When: _____          | <input type="checkbox"/> Defibrillator<br>When: _____          | <input type="checkbox"/> Depression<br>When: _____          |
| <input type="checkbox"/> Diabetes Mellitus<br>When: _____         | <input type="checkbox"/> Diverticular Disease<br>When: _____ | <input type="checkbox"/> Esophageal Cancer<br>When: _____        | <input type="checkbox"/> Gallstones<br>When: _____             | <input type="checkbox"/> Glaucoma<br>When: _____            |
| <input type="checkbox"/> Heart Attack _____ (date)<br>When: _____ | <input type="checkbox"/> Heart Disease<br>When: _____        | <input type="checkbox"/> Heartburn/Reflux<br>When: _____         | <input type="checkbox"/> Hepatitis _____ (type)<br>When: _____ | <input type="checkbox"/> Hiatal hernia<br>When: _____       |
| <input type="checkbox"/> High blood pressure<br>When: _____       | <input type="checkbox"/> High Cholesterol<br>When: _____     | <input type="checkbox"/> Irritable Bowel Syndrome<br>When: _____ | <input type="checkbox"/> Kidney disease<br>When: _____         | <input type="checkbox"/> Pace Maker<br>When: _____          |
| <input type="checkbox"/> Pancreatitis<br>When: _____              | <input type="checkbox"/> Sleep apnea<br>When: _____          | <input type="checkbox"/> Stroke / TIA<br>When: _____             | <input type="checkbox"/> Thyroid disease<br>When: _____        | <input type="checkbox"/> Ulcerative Colitis<br>When: _____  |
| <input type="checkbox"/> Ulcers<br>When: _____                    | <input type="checkbox"/> Bleeding Disorder<br>When: _____    | <input type="checkbox"/> Prostate Cancer<br>When: _____          | <input type="checkbox"/> Difficulty Swallowing<br>When: _____  |   |

**Social History**

**Alcohol**

None

| Type  | Quantity | Frequency |
|-------|----------|-----------|
| _____ | _____    | _____     |

**Marital Status**

Single       Married       Divorced       Widowed

**Caffeine**

None

Intake: \_\_\_\_\_

**Tobacco**

**Smoking Status**

Current every day smoker       Current some day smoker       Former smoker       Never smoker

Smoker, current status unknown       Unknown if ever smoked

**Drug Use**

None

| Type  | Quantity | Frequency |
|-------|----------|-----------|
| _____ | _____    | _____     |



## Family Medical History

No knowledge of family history

No family history of  Colon cancer

Polyps

### Diagnoses

|                     | Mother                | Father                | Sister                | Brother               | Maternal Grandmother  | Maternal Grandfather  | Paternal Grandmother  | Paternal Grandfather  | Other                 |
|---------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Breast Cancer       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Colon cancer        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Colon polyps        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Crohn's Disease     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Diabetes            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Esophageal Cancer   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Gallbladder Disease | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Heart Problems      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Liver Disease       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pancreatic Cancer   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Stomach Cancer      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Throat Cancer       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Thyroid Disease     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Ulcerative Colitis  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other:              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

### Review Of Systems

|                                     |                       |                                       |                       |  |                                   |
|-------------------------------------|-----------------------|---------------------------------------|-----------------------|--|-----------------------------------|
| <b>Allergic/Immunologic</b>         | Yes<br>No             | <b>Gastrointestinal</b>               | Yes<br>No             |  |                                   |
| HIV exposure                        | <input type="radio"/> | abdominal pain                        | <input type="radio"/> |  |                                   |
| persistent infections               | <input type="radio"/> | abdominal swelling and/or bloating    | <input type="radio"/> |  | <b>Musculoskeletal</b>            |
| Skin rashes or itching              | <input type="radio"/> | change in bowel habits                | <input type="radio"/> |  | arthritis                         |
|                                     |                       | constipation                          | <input type="radio"/> |  | back pain                         |
| <b>Cardiovascular</b>               | Yes<br>No             | diarrhea                              | <input type="radio"/> |  | gout                              |
| chest pain                          | <input type="radio"/> | Difficulty swallowing                 | <input type="radio"/> |  | joint deformity                   |
| Shortness of breath                 | <input type="radio"/> | gas                                   | <input type="radio"/> |  | joint pain                        |
| irregular heart beat                | <input type="radio"/> | heartburn                             | <input type="radio"/> |  | muscle weakness or pain           |
| shortness of breath when lying down | <input type="radio"/> | yellowing of skin                     | <input type="radio"/> |  | stiffness                         |
| palpitations                        | <input type="radio"/> | nausea                                | <input type="radio"/> |  |                                   |
| Leg edema                           | <input type="radio"/> | rectal bleeding                       | <input type="radio"/> |  | <b>Neurological</b>               |
| Fainting or near fainting           | <input type="radio"/> | stomach cramps                        | <input type="radio"/> |  | dizziness                         |
|                                     |                       | vomiting                              | <input type="radio"/> |  | fainting                          |
| <b>Constitutional</b>               | Yes<br>No             | Vomiting blood                        | <input type="radio"/> |  | frequent headaches                |
| Fatigue or tiredness                | <input type="radio"/> |                                       |                       |  | migraine                          |
| fever                               | <input type="radio"/> | <b>Genitourinary</b>                  | Yes<br>No             |  | numbness or tingling              |
| loss of appetite                    | <input type="radio"/> | dark urine                            | <input type="radio"/> |  | seizures                          |
| General discomfort                  | <input type="radio"/> | decrease in urine flow                | <input type="radio"/> |  | tremors                           |
| sweats                              | <input type="radio"/> | pain on urination                     | <input type="radio"/> |  | vertigo                           |
| weight gain                         | <input type="radio"/> | frequent urinary infections           | <input type="radio"/> |  | Weakness                          |
| weight loss                         | <input type="radio"/> | frequent urination                    | <input type="radio"/> |  |                                   |
|                                     |                       | Blood in Urine                        | <input type="radio"/> |  | <b>Psychiatric</b>                |
| <b>ENMT</b>                         | Yes<br>No             | impotence                             | <input type="radio"/> |  | anxiety                           |
| difficulty swallowing               | <input type="radio"/> | excessive night time urination        | <input type="radio"/> |  | depression                        |
| dizziness                           | <input type="radio"/> | urethral discharge or incontinence    | <input type="radio"/> |  | difficulty sleeping               |
| double vision                       | <input type="radio"/> |                                       |                       |  | hallucinations                    |
| ear pain                            | <input type="radio"/> | <b>Hematologic/Lymphatic</b>          | Yes<br>No             |  | nervousness                       |
| loss of vision                      | <input type="radio"/> | bleeding gums or palpable lymph nodes | <input type="radio"/> |  | panic attacks                     |
| nasal obstruction                   | <input type="radio"/> | easy bruising                         | <input type="radio"/> |  | paranoia                          |
| nose bleeds                         | <input type="radio"/> | prolonged bleeding                    | <input type="radio"/> |  |                                   |
| photophobia                         | <input type="radio"/> |                                       |                       |  | <b>Respiratory</b>                |
| sore throat                         | <input type="radio"/> | <b>Skin</b>                           | Yes<br>No             |  | asthma                            |
|                                     |                       | allergies                             | <input type="radio"/> |  | cough                             |
| <b>Endocrine</b>                    | Yes<br>No             | dryness                               | <input type="radio"/> |  | shortness of breath               |
| excessive thirst                    | <input type="radio"/> | hives                                 | <input type="radio"/> |  | excessive sputum                  |
| hair loss                           | <input type="radio"/> | itching                               | <input type="radio"/> |  | coughing blood                    |
| heat intolerance                    | <input type="radio"/> | jaundice                              | <input type="radio"/> |  | shortness of breath with exercise |
|                                     |                       | lesions                               | <input type="radio"/> |  | wheezing                          |
|                                     |                       | rashes                                | <input type="radio"/> |  |                                   |

