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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____

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

Ethnicity

◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Patient declines to specify

Sex

◯ Male ◯ Female ◯ Other

Preferred Language

◯ English ◯ French ◯ Haitian; Haitian Creole ◯ Spanish; Castilian ◯ Vietnamese

◯ Patient declines to specify

Contact Preference

◯ Letter ◯ Webmail ◯ Phone ◯ Patient declines to specify Other:_____

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?

Allergies

◯ Patient has no known allergies ◯ Patient has no known drug allergies

◯ Penicillins ◯ Codeine Sulfate ◯ Erythromycin ◯ Sulfa (Sulfonamide Antibiotics) ◯ Adhesive Tape

◯ IV Dye, Iodine Containing ◯ Latex ◯ Anaphylactic or other reaction to Anesthesia Other: _____

Food Allergies ◯ Egg ◯ Lactose ◯ Nuts ◯ Seafood

◯ Shellfish ◯ Wheat ◯ Soybean Other: _____

Immunizations

◯ None

◯ Flu vaccine When: _____ ◯ Hep A When: _____ ◯ Hep B When: _____ ◯ Pneumovax When: _____ ◯ TB skin test When: _____

◯ Meningoccal Vaccine When: _____ ◯ Shingles Vaccine When: _____ Other: _____

Diagnostic Studies/Tests

◯ None

◯ CT Abdomen/Pelvis When: _____ ◯ MRI Abdomen/Pelvis When: _____ ◯ Abdominal Ultrasound When: _____ ◯ Colonoscopy When: _____ ◯ EGD When: _____

◯ EUS When: _____ ◯ ERCP When: _____ ◯ Nuclear Medicine When: _____ ◯ Normal EKG When: _____ ◯ Abnormal EKG When: _____

◯ Normal Stress Test When: _____ ◯ Abnormal Stress Test When: _____ ◯ Normal Hearth Cath When: _____ ◯ Abnormal Heart Cath When: _____ Other: _____

Hospitalization? ◯ Florida Hospital When: _____ ◯ Orlando Regional Medical Center When: _____ ◯ Doctor Phillips Hospital When: _____ Other: _____

Previous Procedures

- ◯ None
- ◯ Gallbladder removed — When:_____
- ◯ Appendectomy — When:_____
- ◯ Colon resection — When:_____
- ◯ Small Bowel Resection — When:_____
- ◯ Laparotomy or Laparoscopy — When:_____
- ◯ Gastric Bypass — When:_____
- ◯ Gastric Lap Band — When:_____
- ◯ Hemorrhoidectomy — When:_____
- ◯ Hemorrhoid Banding — When:_____
- ◯ Abdominoplasty — When:_____
- ◯ Hysterectomy - Abdominal — When:_____
- ◯ Bilateral Tubal Ligation (BTL) — When:_____
- ◯ Mastectomy — When:_____
- ◯ Pacemaker/Defibrillator (AICD) — When:_____
- ◯ Coronary Artery Bypass Graft (CABG) — When:_____
- ◯ Abdominal aortic aneurysm (AAA) repair — When:_____
- ◯ Heart valve replacement — When:_____
- ◯ Heart Stent — When:_____
- ◯ Joint Replacement — When:_____
- ◯ Back Surgery — When:_____
- ◯ Tonsillectomy — When:_____
- ◯ Prostatectomy — When:_____
- ◯ Prostate Radiation — When:_____
- ◯ Ovary Removal — When:_____
- ◯ Fundoplication - Nissen — When:_____
- ◯ Achalasia Surgery — When:_____
- ◯ Electrophysiology Study (EPS) — When:_____
- ◯ Cardiac Valve Surgery — When:_____
- Other:_____
- Other:_____

Past or Present Medical Conditions

- ◯ None

Gastroenterology/Hepatology

- ◯ Colon polyp history — When:_____
- ◯ Colon cancer — When:_____
- ◯ Irritable Bowel Syndrome — When:_____
- ◯ Diverticulosis — When:_____
- ◯ Diverticulitis — When:_____
- ◯ Crohn's Disease — When:_____
- ◯ Ulcerative Colitis — When:_____
- ◯ Gastroesophageal Reflux Disease (GERD) — When:_____
- ◯ Barrett's Esophagus — When:_____
- ◯ Ulcer Disease — When:_____
- ◯ Hepatitis B — When:_____
- ◯ Hepatitis C — When:_____
- ◯ Fatty Liver — When:_____
- ◯ Cirrhosis — When:_____
- ◯ Celiac Disease — When:_____
- ◯ Bowel Obstruction — When:_____
- ◯ Pancreatitis — When:_____
- ◯ Anemia — When:_____
- ◯ H. Pylori Infection — When:_____

Cardiology

- ◯ No Cardiac Conditions — When:_____
- ◯ Require Follow Up With Cardiologist Once a Year — When:_____
- ◯ Require Multiple Visits to Cardiologist Per Year — When:_____
- ◯ Coronary Artery Disease (Heart) — When:_____
- ◯ Congestive Heart Failure — When:_____
- ◯ Heart Attack — When:_____
- ◯ High blood pressure — When:_____
- ◯ Atrial Fibrillation — When:_____

- ⬭ Vascular Disease — When:_____
- ⬭ High Cholesterol — When:_____
- ⬭ Stroke — When:_____
- ⬭ Mini Stroke/TIA — When:_____
- ⬭ Pacemaker — When:_____
- ⬭ Peripheral Vascular Disease — When:_____
- ⬭ Aortic Stenosis — When:_____
- ⬭ Irregular Heart Rate — When:_____
- ⬭ Abdominal Aortic Aneurysm — When:_____
- ⬭ Cardiomyopathy — When:_____
- ⬭ Carotid Artery Disease (Neck) — When:_____
- Other:_____

Pulmonology

- ⬭ No Pulmonary Conditions — When:_____
- ⬭ C.O.P.D. — When:_____
- ⬭ Asthma — When:_____
- ⬭ Sleep apnea — When:_____
- ⬭ Blood Clots — When:_____
- ⬭ Wheezing — When:_____
- ⬭ Bronchiectasis — When:_____
- ⬭ Supplemental Oxygen — When:_____

Other

- ⬭ Lung cancer — When:_____
- ⬭ Skin Cancer — When:_____
- ⬭ Ovarian Cancer — When:_____
- ⬭ Prostate Cancer — When:_____
- ⬭ Breast cancer — When:_____
- ⬭ HIV infection — When:_____
- ⬭ Seizures — When:_____
- ⬭ Anxiety disorder — When:_____
- ⬭ Bipolar disorder — When:_____
- ⬭ Arthritis — When:_____
- ⬭ Current pregnancy — When:_____
- ⬭ Depression — When:_____
- ⬭ HIV exposure — When:_____
- ⬭ Hyperthyroidism — When:_____
- ⬭ Hypothyroidism — When:_____
- ⬭ Fibromyalgia — When:_____
- ⬭ Diabetes Mellitus, Insulin Dependent (Type 1) — When:_____
- ⬭ Diabetes Mellitus, Non-Insulin Dependent (Type 2) — When:_____
- ⬭ Gout — When:_____
- ⬭ Dialysis — When:_____
- ⬭ Kidney disease — When:_____
- ⬭ Kidney stones — When:_____
- ⬭ Tattoos — When:_____
- ⬭ Body piercings — When:_____
- ⬭ I have a Power of Attorney/Healthcare Surrogate — When:_____
- Other:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

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

Alcohol

- ⬭ None
- ⬭ Occasionally
- ⬭ Daily

Caffeine

- ⬭ None

○ Occasionally ○ Daily

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				
○ Chewing Tobacco				

Drug Use

○ None

Type	Quantity	Number	Frequency
○ IV or intranasal drugs			Times / month
○ Recreational			Times / month

Exercise

○ None

○ Regular exercise ○ Occasional exercise

Family Medical History

○ No knowledge of family history

No family history of

○ Celiac sprue ○ Colon cancer

○ Colon polyps ○ Crohn's disease

○ Liver disease ○ Stomach cancer

○ Ulcerative Colitis / IBD

Health Status	Mother	Father	Sister	Brother	Grandmother	Grandfather
Age/Date of Birth						
Healthy	○	○	○	○	○	○
Ill	○	○	○	○	○	○
Alive	○	○	○	○	○	○
Deceased/At Age	○	○	○	○	○	○
Cause of Death						
Diagnoses						
Celiac Disease	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○

Crohn's disease	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Pancreatitis	○	○	○	○	○	○
Barrett's Esophagus	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

None	Y	N
chest pain	○	○
dyspnea with exercise	○	○
irregular heart beat	○	○
orthopnea	○	○
palpitations	○	○
peripheral edema	○	○
syncope	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
malaise	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

ENMT

None	Y	N
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
sore throat	○	○
hearing loss	○	○

Endocrine

None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Eyes

None	Y	N
double vision	○	○
loss of vision	○	○
photophobia	○	○

Gastrointestinal

None	Y	N
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
difficulty swallowing	○	○

Genitourinary

None	Y	N
dark urine	○	○
decrease in urine flow	○	○
dysuria	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○
impotence	○	○
nocturia	○	○
urethral discharge or incontinence	○	○

Hematologic/Lymphatic

None	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○

Integumentary

None	Y	N
allergies	○	○
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○

Musculoskeletal

None	Y	N
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○
vertigo	○	○
memory loss	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Respiratory

None	Y	N
asthma	○	○
cough	○	○
dyspnea	○	○
excessive sputum	○	○
coughing up blood	○	○
shortness of breath with exercise	○	○
wheezing	○	○

Reminder Preference

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

⬭ Yes ⬭ No

Reviewed with

⬭ Patient ⬭ Parent ⬭ Guardian ⬭ Not Present

Signature

Signature Date