Patient Interview Form

Patient Information

PLEASE COMPLETE and MAIL BACK PROMPTLY

FOR OFFICE USE ONLY
PROVIDER: JE DH KK AK DK TM GAM JM BP DR MR AS GW MC TH SM CP KS
LOCATION: BMC MMC PEC INT OFFICE
DATE: ____________________

First Name: ___________________________ Last Name: ____________________________________
MRN: __________________ Date of Birth: __________________ Age: ________________________

Race – select one or more

- ⬭ White/Caucasian
- ⬭ Black or African American
- ⬭ Asian
- ⬭ American Indian or Alaska Native
- ⬭ Native Hawaiian or Other Pacific Islander
- ⬭ Unknown
- ⬭ Patient declines to provide information

Ethnicity

- ⬭ Hispanic or Latino
- ⬭ Not Hispanic or Latino
- ⬭ Patient declines to provide information

Sex

- ⬭ Male
- ⬭ Female
- ⬭ Other

Preferred Language

- ⬭ English
- ⬭ French
- ⬭ Patient declines to specify
- ⬭ Other: ________________

Patient Care Reminder Preference

I would like to receive preventative care and follow up care reminders. ⬭ Yes ⬭ No

Example: Annual Flu Shot reminder

Care Reminder Contact Preference ⬭ Email ⬭ Patient Declines to specify ⬭ Other: __________

Allergies ⬭ Patient has no known allergies ⬭ Patient has no known drug allergies

- ⬭ Eggs
- ⬭ Fentanyl
- ⬭ Latex
- ⬭ Nuts
- ⬭ Penicillin
- ⬭ Sulfa
- ⬭ Versed

Reactions: ____

Current Medications ⬭ **None**

Name	Dose	How Taken?
1.		
2.		
3.		
4.		
5.		
6.		

PGA PIF 2/14/17

Immunizations

☐ **None**

☐ Flu Vaccine When:________
☐ Pneumonia Vaccine When:____________
☐ Shingles Vaccine When:___________
☐ Whooping Cough Vaccine When:____________
☐ TB Test When:________
☐ Hep B Screening When:____________

Pharmacy

Name/Address____

Social History

Occupation: _______________________________ Number of Children: _____________________

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Civil Union

Alcohol ☐ **None**

Quantity Number Frequency

☐ Beer/Wine ____
☐ Hard Liquor____

Tobacco Smoking Status

☐ Current Everyday
☐ Current someday
☐ Former smoker
☐ Never Smoker
☐ Smoker, current status unknown
☐ Light tobacco smoker
☐ Heavy tobacco smoker
☐ Unknown if ever smoked

Drug Use ☐ **None**

Type Quantity Frequency

☐ IV Drug ____
☐ Other ____

Exercise ☐ **None**

Type Duration Frequency

1.____
2.____

Diagnostic Studies/Tests

☐ None

☐ Colonoscopy When:_________
☐ CT Scan When:_______ _
☐ ERCP When:________
☐ EUS When:________
☐ Upper Endoscopy When:____________
☐ Liver Biopsy When: _________
☐ MRCP When:__________
☐ MRI When:_________
☐ Ultrasound When:_________
☐ Recent Labs When:________

Previous Procedures/Surgeries

- [ ] None

- [ ] Abdominal Aneurysm
- [ ] Appendectomy
- [ ] Bowel Surgery
- [ ] Breast Surgery
- [ ] Carotid Artery
- [ ] Cataract Surgery
- [ ] C-Section
- [ ] Coronary Artery Stent
- [ ] Coronary Bypass
- [ ] Defibrillator
- [ ] Gallbladder Removed
- [ ] Heart Valve
- [ ] Hemorrhoids
- [ ] Hernia Repair
- [ ] Hysterectomy
- [ ] Joint Surgery
- [ ] Pacemaker
- [ ] Prostate Surgery
- [ ] Thyroid Surgery
- [ ] Tonsillectomy
- [ ] Tubal Ligation
- [ ] Other: ____

Past or Present Medical Conditions

- [ ] None

Blood	Anemia	Bleeding Disorders	Leukemia	Lymphoma
Cardiac	Atrial Fibrillation	Congestive Heart Failure	Heart Attack	High Blood Pressure
Circulation	Carotid Artery Disease	Deep Vein Thrombosis	Peripheral Vascular Disease	Pulmonary Embolus
Endocrine	Diabetes	Elevated Cholesterol	Osteoporosis	Thyroid Disease
Gastrointestinal	Barrett’s Esophagus Celiac Disease Cirrhosis Colon Cancer Colon Polyps	Crohn’s Disease Diverticulosis GERD/Reflux Hepatitis B Hepatitis C	H. Pylori Irritable Bowel Syn. Lactose Intolerance Liver Disease	Pancreatic Cancer Pancreatitis Stomach Ulcer Ulcerative Colitis
Lungs	Asthma	COPD/Emphysema	Sleep apnea	
Neurology	Dementia	Epilepsy	Parkinsons	Stroke
Psychiatric	Anxiety Schizophrenia	Bipolar Disorder	Depression	Post Traumatic Stress Disorder
Rheumatology	Fibromyalgia	Lupus	Rheumatoid Arthritis	
Urinary	Enlarged Prostate	Kidney Failure	Kidney Stones	Prostate Cancer
Cancer	Type____			

Other Condition(s) Not Listed: ____

Family Medical History

⬭ Family History Unknown

	None	Mother	Father	Daughter	Son	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Diagnoses											
Colon Cancer	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Colon Polyps	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Celiac Disease	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Irritable Bowel Syndrome	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Liver Disease	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Pancreatic Cancer	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Ulcerative Colitis/Crohn’s	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Other:	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭

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 non-identifying demographic information shared with other health care entities.

Example: Health data banks or Medical Registries for the purpose of research in health care trends such as the American Gastroenterology Association

⬭ Yes ⬭ No