Patient Interview Form

FOR OFFICE USE ONLY

PROVIDER: NB GB JE JG DH KK AK TM GAM JM BP DR AS GW MC EF TH CP KS KKS

LOCATION: BMC MMC PEC INT OFFICE

DATE: _____

Patient Information

PLEASE COMPLETE and MAIL BACK PROMPTLY

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.		

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