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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Allergies

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

☐ Penicillins ☐ Morphine ☐ Sulfa ☐ Aspirin ☐ Fentanyl Citrate in NS (PF)

☐ Propofol ☐ Versed ☐ Iodine-Iodine Containing Other:_____ Other:_____

Other:_____ Other:_____ Other:_____ Other:_____ Other:_____

Describe your reaction to each allergy:

Current Medications

☐ None

Name Dose

_____

_____

_____

_____

_____

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_____

Immunizations

☐ None

☐ Hep A When:_____

☐ Hep B When:_____

☐ Flu vaccine When:_____

☐ Pneumococcal conjugate PCV 13 When:_____

☐ Zoster (Shingles) When:_____

☐ Covid-19 Vaccine When:_____

Past or Present Medical Conditions

☐ None

Gastrointestinal

☐ Gastric Ulcer ☐ Barrett's Esophagus ☐ Heartburn (GERD) ☐ Diverticulosis

☐ Colon Polyps ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Irritable Bowel Syndrome

☐ Cirrhosis ☐ Hepatitis ☐ Fatty Liver Disease ☐ Pancreatic Disease

☐ Gastrointestinal cancer Other:_____ Other:_____ Other:_____

Other:_____ Other:_____

Pulmonary

☐ Sedation Problems ☐ Sleep Apnea ☐ Asthma ☐ COPD

☐ Lung Cancer ☐ Chronic Bronchitis Other:_____ Other:_____

Other:_____ Other:_____

Cardiovascular

☐ Defibrillator ☐ Pacemaker ☐ Atrial Fibrillation ☐ Coronary Heart Disease

☐ Blood Clots ☐ High blood pressure ☐ Heart Attack ☐ Stroke

☐ Transient Ischemic Attack (TIA) ☐ Arrhythmia ☐ Stents, Cardiac/Peripheral Other:_____

Other:_____ Other:_____

Other

☐ Colon Cancer ☐ Breast Cancer ☐ Skin Cancer ☐ Prostate Cancer

☐ Uterine Cancer ☐ Ovarian Cancer ☐ Seizures ☐ Diabetes Mellitus

☐ HIV ☐ Glaucoma ☐ Wheelchair Bound ☐ Frailty

☐ Oxygen Dependency ☐ Dementia ☐ Parkinson's Disease ☐ End Stage Renal Failure

☐ Alzheimer's ☐ History of Falls Other:_____ Other:_____

Other:_____ Other:_____

Previous Procedures

- [ ] None

- [ ] Hysterectomy — When:_____
- [ ] Appendectomy — When:_____
- [ ] Gallbladder — When:_____
- [ ] Gastric Bypass — When:_____
- [ ] Heart/Coronary Artery Bypass Graft (CABG) — When:_____
- [ ] Bowel Resection — When:_____ Other:_____
- [ ] Colostomy Bag — When:_____ Other:_____
- [ ] Tracheostomy — When:_____ Other:_____
- Other:_____
- Other:_____

Social History

Occupation:_____

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Unknown
- [ ] Other

Alcohol

- [ ] None
- [ ] Less than 7 per week
- [ ] More than 7 per week

Caffeine

- [ ] None
- [ ] 3 or less daily
- [ ] More than 3 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

Drug Use

- [ ] None

Type	Frequency
[ ] Medical Marijuana Use	
[ ] Recreational drug use (street drugs)	
[ ] IV street drug use	

Exercise

- [ ] None
- [ ] 3 times/week or less
- [ ] 3 times/week or more

Review Of Systems

Constitutional	Y	N
fatigue	○	○
loss of appetite	○	○
weight loss	○	○

Cardiovascular	Y	N
chest pain	○	○
irregular heart beat	○	○
palpitations	○	○
peripheral edema	○	○

ENMT	Y	N
difficulty swallowing	○	○
nose bleeds	○	○
painful swallowing	○	○

Endocrine	Y	N
heat intolerance	○	○
elevated blood sugar	○	○

Eyes	Y	N
loss of vision	○	○
blurred vision	○	○
jaundice (yellow)	○	○

Gastrointestinal	Y	N
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
difficulty swallowing	○	○
early satiety (full too quickly with eating)	○	○

Hematologic/Lymphatic	Y	N
easy bruising	○	○
prolonged bleeding	○	○

Integumentary	Y	N
itching	○	○
rashes	○	○
jaundice (yellow)	○	○

Musculoskeletal	Y	N
back pain	○	○
joint pain	○	○
muscle weakness	○	○

Neurological	Y	N
dizziness	○	○
frequent headaches	○	○
memory loss	○	○

Psychiatric	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○

Respiratory	Y	N
asthma	○	○
cough	○	○
excessive sputum	○	○
dyspnea (shortness of breath)	○	○

Reviewed with

○ Patient ○ Parent ○ Guardian ○ Not Present

Signature

Signature Date