Patient Interview Form Consent

Patient Name: ____

Patient DOB: _________________ Patient MRN: _________________

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 demographic information shared with other health care entities.

- [ ] Yes
- [ ] No

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

Patient Interview Form

Patient Information

First Name:________________ Last Name:________________

MRN:________________ Date Of Birth:________________

Age:________________ Notes:________________

Sex

- Male
- Female
- Other

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

Preferred Language

- English
- Spanish; Castilian
- Vietnamese
- Patient declines to specify

Contact Preference

- Letter
- Email
- Cell phone
- Telephone call - Home
- Patient declines to specify

Other:________

Pharmacy

Name	Address	Phone

Allergies

- [ ] Patient has no known allergies
- [ ] Patient has no known drug allergies
- [ ] Latex
- [ ] Penicillins
- [ ] aspirin
- [ ] Iodine-Iodine Containing
- [ ] Sulfa (Sulfonamide Antibiotics)
- [ ] Codeine Sulfate

Other: ____ Other: ____ Other: ____ Other: ____

Current Medications

- [ ] None

Name	Dose	How taken?

Past or Present Medical Conditions

- [ ] None

Arthritis	Artificial Heart Valve	Alzheimer's Disease	Anemia	Asthma / Bronchitis
Bleeding problems	Colon cancer	COPD / Emphysema	Crohn's Disease	Depression
Diabetes	Fibrositis / Fibromyalgia	Gallstones	Glaucoma	Heart disease
Heart Murmurs	Hepatitis A	Hepatitis B	Hepatitis C	High blood pressure
Colon polyp history	HIV	Irritable Bowel Syndrome	Kidney disease	Parkinson's Disease
Reflux Disease (GERD)	Rheumatic Fever	Seizures	Ulcer Disease	Stroke
Thyroid disease	Tuberculosis	Ulcerative Colitis	Defibrillator	Other:______________
Other:______________	Other:______________			

Previous Procedures

- [ ] None

Defibrillator Placement	Pacemaker Insertion	Other:______________
When:______________	When:______________	

Immunizations

- [ ] None

Influenza, seasonal, injectable	Pneumonia vaccine	Other:______________
When:______________	When:______________	

Diagnostic Studies/Tests

- [ ] None

Abdominal Ultrasound	EGD	Colonoscopy	Flexible Sigmoidoscopy	CT Abdomen
When:______________	When:______________	When:______________	When:______________	When:______________
Mammography; bilateral	Other:______________			
When:______________				

Social History

Occupation:________________________ Number of Children:________________________

Marital Status

Single	Married	Divorced	Separated	Widowed
Civil Union	Unknown	Other		

Alcohol

- [ ] None

Type	Quantity	Number	Frequency
spirits			

Caffeine

- ◯ None
- ◯ caffeine   Intake:______________________

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

Drug Use

- ◯ None

Type	Quantity	Number	Frequency
◯ Marijuana			
◯ Cocaine			
◯ IV Drugs			

Family Medical History

- ◯ No knowledge of family history

No family history of

- ◯ Celiac sprue
- ◯ Colon polyps
- ◯ Ulcerative Colitis / IBD
- ◯ Colon cancer
- ◯ Liver disease

Health Status	Father	Mother	Brother	Sister
Deceased/At Age	◯ ____	◯ ____	◯ ____	◯ ____
Cause of Death	______	______	______	______

Diagnoses	Father	Mother	Brother	Sister
History of colon cancer	◯	◯	◯	◯
History of colon polyps	◯	◯	◯	◯
Crohn's disease, colon	◯	◯	◯	◯
Diabetes mellitus (Type I)	◯	◯	◯	◯
Diabetes mellitus (Type II)	◯	◯	◯	◯
Gallstones	◯	◯	◯	◯
Pancreatitis	◯	◯	◯	◯
Ulcer, gastric	◯	◯	◯	◯
Ulcerative colitis	◯	◯	◯	◯
Other:	◯	◯	◯	◯
Other:	◯	◯	◯	◯

Review Of Systems

Allergic/Immunologic

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

Cardiovascular

☐ None	Y	N
chest pain	○	○
irregular heart beat	○	○
Shortness of Breath	○	○
Swelling of Ankles	○	○
Pacemaker	○	○
Defibrillator	○	○
Stents	○	○

Constitutional

☐ None	Y	N
Feeling Tired	○	○
fever	○	○
sweats/chills	○	○
weight gain	○	○
weight loss	○	○
Pregnant	○	○
Jaundice	○	○

ENMT

☐ None	Y	N
difficulty swallowing	○	○
nose bleeds	○	○
sore throat	○	○
Hearing Aid	○	○
Hoarseness	○	○
Sinus Problems	○	○

Endocrine

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

Eyes

☐ None	Y	N
Blurred Vision	○	○
Glaucoma	○	○
Contacts or Glasses	○	○

Genitourinary

☐ None	Y	N
frequent urination	○	○
Blood in Urine	○	○
Incontinence	○	○

Gastrointestinal

☐ None	Y	N
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
heartburn	○	○
nausea	○	○
vomiting	○	○
Anal Itching	○	○
Anal Pain/Sore	○	○
Appetite loss	○	○
Belching	○	○
Bloating	○	○
Difficulty Swallowing	○	○
Get full easily	○	○
Incontinence of Stool	○	○
Pain on Swallowing	○	○
Pain when Defecating	○	○
Black / Tarry Stool	○	○
Maroon Stool	○	○
Rectal Bleeding	○	○
Vomiting Blood	○	○
"Coffee Grounds"	○	○
blood in stool	○	○

Hematologic/Lymphatic

☐ None	Y	N
Anemia	○	○
easy bleeding/bruising	○	○
past blood transfusion	○	○

Integumentary

☐ None	Y	N
itching	○	○
skin ulcers	○	○
rashes	○	○

Musculoskeletal

☐ None	Y	N
Back pain	○	○
Joint pain	○	○
Muscle Pain	○	○
Joint Replacements	○	○
Joint Swelling	○	○

Neurological

☐ None	Y	N
fainting	○	○
frequent headaches	○	○
seizures	○	○
Brain/Spinal Injury	○	○
Confused	○	○
Weakness/Numbness	○	○

Psychiatric

☐ None	Y	N
anxiety	○	○
depression	○	○

Respiratory

☐ None	Y	N
Chronic cough	○	○
Sleep Apnea	○	○
Use of C-PAP	○	○
Difficulty opening Mouth	○	○
Positive TB skin test	○	○
wheezing	○	○
DifficultyTurning head	○	○
Use of Oxygen @ Home	○	○