Patient Interview Form

PATIENT INFORMATION

First Name: _____ Last Name: _____ Date of Birth: _____

Email: _____ Phone Number: _____

Contact Preference
☐ Home phone ☐ Cell phone ☐ Email ☐ Patient declines to specify

Sex
☐ Male ☐ Female ☐ Other

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 ☐ Russian ☐ Spanish; Castilian ☐ Patient declines to specify

Allergies
☐ Patient has no known allergies ☐ Patient has no known drug allergies
☐ Penicillin sulfa (sulfonamide antibiotics) ☐ Aspirin ☐ Vicodin ☐ Codeine
☐ Propofol analogues ☐ Iodine ☐ Other _____

Current Medications (Including prescription, over-the-counter, and herbs/supplements)
☐ NONE

Name Dose

_____

_____

_____

_____

_____

_____

_____

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Past or Present Medical Conditions

☐ NONE
☐ Acid Reflux
☐ Barrett's Esophagus
☐ Esophageal Narrowing/Strictures
☐ Hepatitis
☐ Glaucoma
☐ Cataracts
☐ Anxiety
☐ Allergies
☐ Sinusitis
☐ Migraine
☐ Depression
☐ Sleep Apnea
☐ Throat Cancer
☐ Breast Cancer
☐ Lung Cancer
☐ Skin Cancer
☐ Prostate Cancer
☐ Colon Cancer
☐ Other Cancer: _____
☐ High Blood Pressure
☐ High Cholesterol
☐ Stroke
☐ Heart Attack
☐ Diabetes
☐ Anemia
☐ Hemophilia
☐ Other Bleeding Disorder: _____
☐ Blood Clots/DVT
☐ Thyroid Disorder
☐ Kidney Failure
☐ Fibromyalgia
☐ Asthma
☐ COPD
☐ Tuberculosis
☐ HIV
☐ OTHER: _____

Previous Procedures

☐ NONE

Name Date Complications?

_____

_____

_____

_____

_____

_____

_____

Have you ever had any problems with anesthesia? ☐ No ☐ Yes: _____

Diagnostic Studies/Tests

☐ NONE
☐ Allergy Testing
Date: _____
☐ Swallow study (Modified Barium Swallow or Esophagram?)
Date and Location: _____

☐ MRI of head/neck
Date and Location: _____
☐ Thyroid or neck ultrasound
Date and Location: _____

☐ CT scan of sinuses/face head or neck
Date and Location: _____

Occupation: _____ Marital Status: _____

Alcohol

☐ NONE
☐ Less than seven drinks weekly, and no more than three drinks on any one occasion
☐ More than seven drinks weekly, and/or more than three drinks on any one occasion
☐ Less than 14 drinks weekly and no more than four drinks on any one occasion
☐ More than 14 drinks weekly and/or more than four drinks on any one occasion
☐ Former alcohol abuse, now sober

Tobacco - Smoking Status

☐ Current every day smoker
☐ Current some day smoker
☐ Former smoker
☐ Never a smoker
☐ Smoker, current status unknown
☐ Light tobacco smoker
☐ Heavy tobacco smoker
☐ Unknown if ever smoked

Drug Use

☐ None ☐ Past use of drugs ☐ Current use of drugs
Type: _____

Caffeine Use

☐ None ☐ 1 cup per day ☐ 2-3 cups per day ☐ 4 or more cups per day

Family Medical History

☐ No known knowledge of family history

Please provide the following information with regard to your relatives:
If living, age, state of health/illnesses; if deceased, age and cause of death

Mother _____

Father _____

Siblings _____

Children _____

Other Family _____

Review of Systems

ABDOMINAL PAIN

☐ None	Y	N
Abdominal distension, bloating	☐	☐
Nighttime awakening from abdominal pain	☐	☐
Abnormal bowel movements	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Loose stools	☐	☐
Recent changes in bowel habits	☐	☐
Bloody diarrhea	☐	☐
Rectal bleeding	☐	☐
Black, tarry stools	☐	☐
Rectal pain	☐	☐
Fecal incontinence	☐	☐
Heartburn	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Belching	☐	☐
Vomiting blood	☐	☐
Gas	☐	☐

ALLERGIC IMMUNOLOGIC

☐ None	Y	N
Persistent infections	☐	☐

CARDIOVASCULAR

☐ None	Y	N
Chest pain	☐	☐
Irregular heart beat	☐	☐
Syncope	☐	☐
Heart murmur	☐	☐

MUSCULOSKELETAL

☐ None	Y	N
Arthritis	☐	☐
Back pain	☐	☐
Joint pain	☐	☐
Stiffness	☐	☐
Swelling	☐	☐

ENDOCRINE

☐ None	Y	N
Excessive thirst	☐	☐
Heat intolerance	☐	☐
Cold intolerance	☐	☐
Excessive urination	☐	☐

EYES

☐ None	Y	N
Yellowing of eyes	☐	☐
Redness of eyes	☐	☐

GENITOURINARY

☐ None	Y	N
Dark urine	☐	☐
Dysuria	☐	☐
Frequent urination	☐	☐
Urinary incontinence	☐	☐
Urgency	☐	☐
Heavy menstrual periods	☐	☐

HEMATOLOGIC/LYMPHATIC

☐ None	Y	N
Easy bruising	☐	☐
Prolonged bleeding	☐	☐
Swollen lymph nodes	☐	☐
Recent anemia	☐	☐

INTEGUMENTARY

☐ None	Y	N
Itching	☐	☐
Yellowing of skin	☐	☐
Lesions	☐	☐
Rashes	☐	☐

NEUROLOGICAL

☐ None	Y	N
Dizziness	☐	☐
Seizures	☐	☐
Confusion	☐	☐

PSYCHIATRIC

☐ None	Y	N
Anxiety	☐	☐
Depression	☐	☐
Nervousness	☐	☐
Agitation	☐	☐

RESPIRATORY

☐ None	Y	N
Cough	☐	☐
Shortness of breath	☐	☐

CONSTITUTIONAL

☐ None	Y	N
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Sweats	☐	☐
Loss of appetite	☐	☐
Weight loss	☐	☐

ENMT

☐ None	Y	N
Difficulty swallowing	☐	☐
Dizziness	☐	☐
Sinus pain	☐	☐
Ringing in the ears	☐	☐
Hoarseness	☐	☐
Neck swelling	☐	☐

Consent to Import Medication History
I consent to obtaining a history of my medications purchased at pharmacies.
☐ Yes ☐ No

Reminder Preference
I would like to receive preventative care and follow-up care reminders. ☐ Yes ☐ No

Patient Contact Information Restriction
The HIPAA privacy rule gives you the right to request a restriction on uses and disclosures of your Protected Health Information.

I wish to be contacted in the following manner **(please check all that apply)**:

☐ Home Phone (_____) _____ - _____
- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with callback number only

☐ Cell Phone (_____) _____ - _____
- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with callback number only

☐ Work Phone (_____) _____ - _____
- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with callback number only

☐ I hereby consent to the release of my medical information to the people listed below. The authorization will be in effect until I change it.

☐ I hereby decline the release of my medical information to anybody. This authorization will be in effect until I change it.

Name	Relationship

Pharmacy

Name Address Phone

Reviewed with
☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

Signature Date