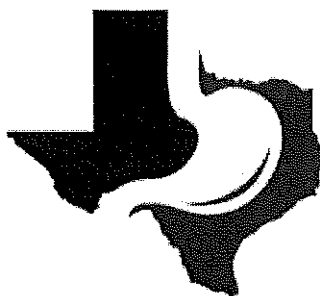

5115 80TH ST Lubbock TX, 79424
P# (806)788-4368 F# (806)513-2863

Patient Interview Form

Patient Information

First Name:______________________ Last Name:______________________

Date Of Birth:______________________

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
- ⬭ Other Race
- ⬭ Unknown
- ⬭ Patient declines to specify
- ⬭ Prohibited by state law

Ethnicity

- ⬭ Hispanic or Latino
- ⬭ Not Hispanic or Latino
- ⬭ Patient declines to specify
- ⬭ Prohibited by state law
- ⬭ Unknown

Sex

- ⬭ Male
- ⬭ Female
- ⬭ Other
- ⬭ Unknown

Preferred Language

- ⬭ English
- ⬭ Patient declines to specify

Contact Preference

- ⬭ Letter
- ⬭ Email
- ⬭ Patient declines to specify
- Other:__________

Pharmacy

____

Name Address Phone

Allergies

- ◯ Patient has no known allergies
- ◯ Patient has no known drug allergies

- ◯ Adhesive Tape
- ◯ Codeine Sulfate
- ◯ Erythromycin
- ◯ Penicillins
- ◯ Shellfish
- ◯ Iv Dye, Iodine Containing
- ◯ Latex gloves

Other: ______________

Current Medications

- ◯ None

Name	Dose	How taken?

Immunizations

- ◯ None

- ◯ Flu vaccine When: ______________
- ◯ Hep A When: ______________
- ◯ Hep B When: ______________
- ◯ Pneumovax When: ______________
- ◯ TB skin test When: ______________

Other: ______________

Diagnostic Studies/Tests

- ◯ None

- ◯ Colonoscopy When: ______________
- ◯ EGD When: ______________
- ◯ CT Abdomen/Pelvis When: ______________
- ◯ MRI Abdomen/Pelvis When: ______________
- ◯ ERCP When: ______________

Other: ______________

Previous Procedures

- ◯ None

- ◯ Gallbladder removed
- ◯ Appendectomy
- ◯ Colon resection
- ◯ Small Bowel Resection
- ◯ Exploratory Laparoscopy
- ◯ Gastric Bypass
- ◯ Gastric Lap Band
- ◯ Hemorrhoidectomy
- ◯ Hemorrhoid banding
- ◯ Abdominoplasty
- ◯ Hysterectomy - Abdominal
- ◯ Bilateral Tubal Ligation (BTL)
- ◯ Mastectomy R Breast
- ◯ Pacemaker Insertion
- ◯ Defibrillator Placement
- ◯ Coronary Artery Bypass Graft (CABG)
- ◯ Abdominal aortic aneurysm (AAA) repair
- ◯ Heart valve replacement
- ◯ Cardiac Cath - with stent placement
- ◯ Joint Replacement
- ◯ Back Surgery
- ◯ Fibromyalgia

Other: ______________ Other: ______________

Past or Present Medical Conditions

- ◯ None

Gastroenterology/Hepatology

- ◯ Colon polyp history
- ◯ Colon cancer
- ◯ Irritable Bowel Syndrome
- ◯ Diverticulitis
- ◯ Crohn's Disease
- ◯ Ulcerative Colitis
- ◯ Gastroesophageal Reflux Disease (GERD)
- ◯ Barrett's Esophagus
- ◯ Ulcer Disease
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ Fatty Liver
- ◯ Cirrhosis
- ◯ Celiac Disease
- ◯ Bowel Obstruction
- ◯ Pancreatitis

	⬭ Anemia	Other: ______	Other: ______	Other: ______
Cardiology	⬭ Coronary Artery Disease	⬭ Congestive Heart Failure	⬭ Heart Attack	⬭ High blood pressure
	⬭ Atrial Fibrillation	⬭ Vascular Disease	⬭ High Cholesterol	⬭ Stroke
	⬭ Transient Ischemic Attack	⬭ Valvular heart disease	⬭ Pacemaker	⬭ Coronary Artery Stents
	Other: ______	Other: ______		
Pulmonology	⬭ C.O.P.D.	⬭ Asthma	⬭ Sleep apnea	⬭ Blood Clots (leg)
	⬭ Blood Clots (lung)	⬭ Wheezing	Other: ______	Other: ______
Other	⬭ Anxiety disorder	⬭ Arthritis	⬭ Bipolar disorder	⬭ Body piercings
	⬭ Breast cancer	⬭ Current pregnancy	⬭ Depression	⬭ Diabetes Mellitus, Insulin Dependent (Type 1)
	⬭ Diabetes Mellitus, Non-Insulin Dependent (Type 2)	⬭ Fibrositis / Fibromyalgia	⬭ Gout	⬭ HIV exposure
	⬭ HIV infection	⬭ Hypothyroidism	⬭ Kidney disease	⬭ Kidney stones
	⬭ Lung cancer	⬭ Ovarian Cancer	⬭ Prostate Cancer	⬭ Skin Cancer
	⬭ Seizures	⬭ Tattoos		

Social History

Occupation: ______ Number of Children: ______

Marital Status

⬭ Single ⬭ Married ⬭ Divorced ⬭ Separated ⬭ Widowed
⬭ Civil Union ⬭ Unknown ⬭ Other

Alcohol

⬭ None

⬭ Occasionally ⬭ Daily

Caffeine

⬭ None

⬭ Occasionally ⬭ 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

Type	Started	Quit	Quantity	Frequency
⬭ Cigarettes				
⬭ Cigar				
⬭ Chewing Tobacco				

Drug Use

⬭ None

Type	Quantity	Number	Frequency
⬭ IV or intranasal drugs			Times / month
⬭ Recreational			Times / month

Exercise

- ○ None
- ○ Regular exercise
- ○ Occasional exercise

Family Medical History

○ No knowledge of family history

No family history of

- ○ Celiac sprue
- ○ Colon polyps
- ○ Liver disease
- ○ Ulcerative Colitis / IBD
- ○ Colon cancer
- ○ Crohn's disease
- ○ Stomach cancer

Health Status	Mother	Father	Sister	Brother	Grandmother	Grandfather
Age/Date of Birth	____	____	____	____	____	____
Healthy	○	○	○	○	○	○
Ill	○	○	○	○	○	○
Seriously Ill	○	○	○	○	○	○
Disabled	○	○	○	○	○	○
In Remission	○	○	○	○	○	○
Alive	○	○	○	○	○	○
Deceased/At Age	○____	○____	○____	○____	○____	○____
Cause of Death	____	____	____	____	____	____

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather
Celiac Disease	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

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

Cardiovascular

( ) None	Y	N
chest pain	○	○
dyspnea with exercise	○	○
irregular heart beat	○	○
orthopnea	○	○
palpitations	○	○
peripheral edema	○	○
syncope	○	○

Constitutional

( ) None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
malaise	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

ENMT

( ) None	Y	N
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
sore throat	○	○
hearing loss	○	○

Endocrine

( ) None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Eyes

( ) None	Y	N
double vision	○	○
loss of vision	○	○
photophobia	○	○

Gastrointestinal

( ) None	Y	N
difficulty swallowing	○	○
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○

Genitourinary

( ) None	Y	N
dark urine	○	○
decrease in urine flow	○	○
dysuria	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○
impotence	○	○
nocturia	○	○
urethral discharge or incontinence	○	○

Hematologic/Lymphatic

( ) None	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○

Integumentary

( ) None	Y	N
allergies	○	○
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○

Musculoskeletal

( ) None	Y	N
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

( ) None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○
vertigo	○	○
memory loss	○	○

Psychiatric

( ) None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Respiratory

( ) None	Y	N
asthma	○	○
cough	○	○
dyspnea	○	○
excessive sputum	○	○
coughing up blood	○	○
shortness of breath with exercise	○	○
wheezing	○	○

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 preventive care and follow up care reminders.

- [ ] Yes
- [ ] No

Reviewed with

- [ ] Patient
- [ ] Parent
- [ ] Guardian
- [ ] Not Present

Signature

Signature

Date