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LabCorp# 42119461 Quest # 21262 CPL # 6213

Patient Interview Form

Patient Information

First Name: ____________________ Last Name: ____________________
MRN: ____________________ Date Of Birth: ____________________
Age: ____________________

Email
Please check one as your preferred email for communications
- ◯ Personal: ____________________
- ◯ Work: ____________________

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

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

Preferred Language
- ◯ English
- ◯ Korean
- ◯ Spanish; Castilian
- ◯ Patient declines to specify

Contact Preference
- ◯ Telephone call
- ◯ Portal
- ◯ Patient declines to specify
- Other: ____________

Allergies

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

Food ◯ Eggs ◯ Nuts ◯ Shellfish

Medication
- ◯ Aspirin
- ◯ Cipro
- ◯ Codeine
- ◯ Demerol
- ◯ Fentanyl

- [ ] Flagyl
- [ ] Iodine
- [ ] IV dye
- [ ] Levaquin
- [ ] Morphine
- [ ] Penicillins
- [ ] Versed
- [ ] Sulfa
- [ ] Latex

Other: ____________

- [ ] Manifestations/Reactions: ____________

Immunizations

- [ ] None
- [ ] Hepatitis B vaccine When: ____________
- [ ] Hepatitis A vaccine When: ____________
- [ ] Influenza vaccine When: ____________
- [ ] Influenza, vaccine rejected When: ____________
- [ ] Pneumovax vaccine When: ____________
- [ ] Tetanus vaccine When: ____________
- [ ] Varicella/VZV vaccine When: ____________
- [ ] Moderna COVID-19 When: ____________
- [ ] Pfizer COVID-19 When: ____________
- [ ] Janssen COVID-19 When: ____________

Current Medications

- [ ] None

Name	Dose	How taken?

Pharmacy

Name	Address	Phone

Past Medical History

- [ ] None

Cancers:

- [ ] Colon
- [ ] Esophageal
- [ ] Liver
- [ ] Small intestine
- [ ] Stomach
- [ ] Kidney
- [ ] Pancreas
- [ ] Bladder
- [ ] Lymphoma
- [ ] Lung
- [ ] Skin
- [ ] Prostate
- [ ] Breast
- [ ] Cervical
- [ ] Ovarian
- [ ] Uterine

Other: ____________

Liver:

- [ ] Cirrhosis of Liver
- [ ] Fatty liver
- [ ] Hepatitis

Other: ____________

Digestive:

- [ ] Acid reflux
- [ ] Barrett's esophagus
- [ ] Celiac sprue
- [ ] Colon polyps
- [ ] Crohn's disease
- [ ] Diverticulitis (infected)
- [ ] Diverticulosis
- [ ] H. pylori
- [ ] Irritable bowel syndrome
- [ ] Pancreatitis
- [ ] Ulcer
- [ ] Ulcerative colitis

Other: ____________

Miscellaneous:

- [ ] Anxiety/Panic attacks
- [ ] Anemia
- [ ] Arthritis
- [ ] Asthma
- [ ] Atrial fibrillation
- [ ] Congestive heart failure
- [ ] Coronary artery disease
- [ ] Depression
- [ ] Diabetes
- [ ] Emphysema
- [ ] Endometriosis
- [ ] Fibromyalgia
- [ ] Glaucoma
- [ ] Heart attack
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] HIV
- [ ] Kidney disease
- [ ] Lupus
- [ ] Osteopenia
- [ ] Osteoporosis
- [ ] Seizure disorder
- [ ] Sleep apnea
- [ ] Stroke/TIA
- [ ] Thyroid, overactive
- [ ] Thyroid, underactive

Other: ____________

Previous Gastroenterology Procedures

- None
- Colonoscopy
- EGD/Upper endoscopy
- ERCP
- Endoscopic ultrasound/EUS
- Small bowel capsule
- Liver biopsy

Other: ____________________

Surgical Procedures

- None
- Appendectomy
- C-Section
- Cataract surgery
- Colon resection
- Coronary artery bypass
- Coronary/Stent
- Defibrillator
- Gallbladder removed
- Gastric bypass
- Heart valve replacement/repair
- Hemorrhoidectomy
- Hiatal hernia surgery (for reflux)
- Uterus and Ovaries removed
- Ovaries removed
- Uterus removed
- Inguinal hernia surgery (groin)
- Joint surgery / replacement
- Lap band
- Liver transplant
- Mastectomy
- Pacemaker
- Prostatectomy
- Tonsillectomy
- Tubal ligation
- Ulcer surgery
- Umbilical hernia surgery (belly-button)

Other: ____________________

Social History

Occupation: ____________________

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed
- Other

Alcohol

- None
- Less than 7 drinks per week
- More than 7 drinks per week
- I quit using alcohol

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

- Cigar
- Chewing Tobacco

Drug Use

- None
- I have used recreational drugs in the past
- I am currently using recreational drugs
- I have been treated for substance abuse

Family Medical History

- No knowledge of family history

No family history of

- Colon cancer
- Polyps

	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Grandmother	Grandfather	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle	Other

Diagnoses							Maternal	Maternal	Paternal	Paternal					
Colon Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Crohn's disease/Ulcerative colitis	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Kidney cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Uterine cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Stomach cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Bladder cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pancreatic cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Ovarian cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Review Of Systems

Gastrointestinal

None

	Y	N
abdominal pain	○	○
anorectal pain/itching	○	○
bloating/gas	○	○
blood in stool	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
stool incontinence (leakage)	○	○
heartburn/reflux	○	○
difficulty swallowing	○	○
nausea	○	○
vomiting	○	○
black tarry stools	○	○

Genitourinary

None

	Y	N
dark urine	○	○
heavy menstruation	○	○
pregnancy	○	○
frequent urination	○	○
blood in urine	○	○

Integumentary

None

	Y	N
itching	○	○
jaundice	○	○
rashes	○	○

Cardiovascular

None

	Y	N
heart murmur	○	○
irregular heart beat	○	○
hand/ankle swelling	○	○
rapid heart rate/palpitations	○	○
chest pain	○	○

Neurological

None

	Y	N
frequent headaches	○	○
memory loss/confusion	○	○
numbness or tingling	○	○

Endocrine

None

	Y	N
cold intolerance	○	○
excessive thirst	○	○

Constitutional

None

	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
night sweats	○	○
weight gain	○	○
weight loss	○	○

Psychiatric

None

	Y	N
anxiety	○	○
depression	○	○

ENMT

None

	Y	N
double vision	○	○
eye irritation	○	○
eye pain	○	○
eye redness	○	○
sore throat	○	○
hoarseness	○	○
mouth sores	○	○

Hematologic/Lymphatic

None

	Y	N
easy bruising	○	○
prolonged bleeding	○	○

Musculoskeletal

None

	Y	N
back pain	○	○
joint pain	○	○

Respiratory

None

	Y	N
frequent cough	○	○
snoring	○	○
sleep apnea	○	○
wheezing	○	○
shortness of breath	○	○

Allergic/Immunologic

None

	Y	N
allergies	○	○

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