

HARFORD ENDOSCOPY CENTER

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Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

MRN: _____ Date Of Birth: _____

Age: _____

Race

- White/Caucasian Black or African American Asian Hispanic or Latino American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander Mixed Other Unknown Patient declines to provide information
- Prohibited by state law

Ethnicity

- Hispanic or Latino Not Hispanic or Latino Patient declines to provide information Prohibited by state law

Preferred Language

Other: _____

Allergies

- Patient has no known allergies Patient has no known drug allergies
- Latex Other: _____

Pharmacy

Name: _____

Current Medications

None

Name	Dose	How taken?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations

None

Hep A

Hep B

Pneumovax

When: _____ When: _____ When: _____

Diagnostic Studies/Tests

None

Upper GI X-Ray

Endoscopy

Small Bowel X-Ray

Camera Pill Examination

Colonoscopy

When: _____ When: _____ When: _____ When: _____ When: _____

CT Scan
Abdomen/Pelvis

Abdominal U/S

ERCP

EUS

Other: _____

When: _____

Past or Present Medical Conditions

None

Abnormal Liver
Blood Tests

Anemia

Barret's
Esophagus

Celiac Sprue

Cirrhosis

When: _____ When: _____ When: _____ When: _____ When: _____

Colon Cancer

Colon polyps

Crohn's Disease

Diverticulosis

Esophageal
Cancer

When: _____ When: _____ When: _____ When: _____ When: _____

Gallstones

GERD

Gastrointestinal
Bleeding

Hemorrhoids

Hepatitis B

When: _____ When: _____ When: _____ When: _____ When: _____

Hepatitis C

Liver Disease

Pancreatitis

Ulcer Disease

Ulcerative Colitis

When: _____ When: _____ When: _____ When: _____ When: _____

History of Blood
Transfusions

Angina

Arthritis

Asthma

Atrial Fibrillation

When: _____ When: _____ When: _____ When: _____ When: _____

Blood Clots
(DVT)

Breast cancer

Chronic Lung
Disease

Congestive
Heart Failure

Coronary Artery
Disease

When: _____ When: _____ When: _____ When: _____ When: _____

Diabetes Insulin
Dependent -
Type I

Diabetes Non-
Insulin
Dependent Type
II

Endometriosis

Gynecological
Cancer

Kidney Disease

When: _____ When: _____ When: _____ When: _____ When: _____

Heart Attack

High blood
pressure

High Cholesterol

Lung cancer

Prostate Cancer

When: _____ When: _____ When: _____ When: _____ When: _____

Seizure Disorder

Stroke

Thyroid Disorder

Other

When: _____ When: _____ When: _____ When: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

- Single Married Divorced Separated Widowed
 Civil Union

Tobacco

Smoking Status

- Current every day smoker Current some day smoker Former smoker Never smoker
 Smoker, current status unknown Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
<input type="radio"/> Cigarettes	_____	_____	_____	_____
<input type="radio"/> Cigar	_____	_____	_____	_____
<input type="radio"/> Pipe	_____	_____	_____	_____
<input type="radio"/> Chewing Tobacco	_____	_____	_____	_____

Alcohol

- None Rarely Quit using alcohol Daily Less than 2 days/week More than 2 days/week
 Recovering alcoholic

Caffeine

- None

Intake: _____

Drug Use

- None
 I currently have a recreational drug addiction I have used recreational drugs in the past I currently have/or had a pill addiction I have been treated for substance abuse

Exercise

- None

Type	Quantity	Frequency
_____	_____	_____

Review Of Systems

ENMT	Yes No	Hematologic/Lymphatic	Yes No
glaucoma	<input type="radio"/>	anemia	<input type="radio"/>
difficulty swallowing	<input type="radio"/>	bleeding disorder	<input type="radio"/>
hoarseness	<input type="radio"/>	blood transfusions	<input type="radio"/>
mouth sores	<input type="radio"/>	clots	<input type="radio"/>
sore throat	<input type="radio"/>	aneurysm	<input type="radio"/>
Allergic/Immunologic	Yes No	Integumentary	Yes No
HIV exposure	<input type="radio"/>	hives	<input type="radio"/>
food allergy	<input type="radio"/>	rashes	<input type="radio"/>
		itching	<input type="radio"/>
Cardiovascular	Yes No	Musculoskeletal	Yes No
murmur	<input type="radio"/>	arthritis	<input type="radio"/>
chest pain	<input type="radio"/>	gout	<input type="radio"/>
swelling of legs	<input type="radio"/>		
irregular heart beat	<input type="radio"/>	Neurological	Yes No
high blood pressure	<input type="radio"/>	seizures	<input type="radio"/>
		stroke	<input type="radio"/>
Constitutional	Yes No	mini-stroke	<input type="radio"/>
fatigue	<input type="radio"/>		
loss of appetite	<input type="radio"/>	Psychiatric	Yes No
weight gain	<input type="radio"/>	anxiety	<input type="radio"/>
weight loss	<input type="radio"/>	depression	<input type="radio"/>
fever	<input type="radio"/>	hallucinations/paranoia	<input type="radio"/>
		panic attacks	<input type="radio"/>
Endocrine	Yes No	suicidal thoughts	<input type="radio"/>
diabetes	<input type="radio"/>		
hyper/hypothyroidism	<input type="radio"/>	Respiratory	Yes No
		pneumonia	<input type="radio"/>
Gastrointestinal	Yes No	asthma	<input type="radio"/>
indigestion	<input type="radio"/>	chronic cough	<input type="radio"/>
peptic ulcer disease	<input type="radio"/>	coughing up blood	<input type="radio"/>
hepatitis	<input type="radio"/>	positive TB skin test or TB exposure	<input type="radio"/>
gall bladder disease	<input type="radio"/>	shortness of breath	<input type="radio"/>
pancreatitis	<input type="radio"/>		
diarrhea	<input type="radio"/>		
constipation	<input type="radio"/>		
rectal bleeding	<input type="radio"/>		
nausea	<input type="radio"/>		
vomiting	<input type="radio"/>		
food intolerance	<input type="radio"/>		
swallowing pain	<input type="radio"/>		
abdominal pain	<input type="radio"/>		
abdominal swelling	<input type="radio"/>		
change in bowel habits	<input type="radio"/>		
gas	<input type="radio"/>		
heartburn	<input type="radio"/>		
jaundice	<input type="radio"/>		
	Yes No		
Genitourinary			
kidney stones	<input type="radio"/>		
dark urine	<input type="radio"/>		

Reviewed with

Patient Parent Guardian Not Present

Signature

Signature

Date