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## Patient Interview Form

### Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
MRN: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_  
Age: \_\_\_\_\_ Notes: \_\_\_\_\_

**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  Unknown

**Sex**  
 Male  Female  Other  Unknown

**Preferred Language**  
 English  Spanish; Castilian  Patient declines to specify

**Contact Preference**  
 Patient Portal  Patient declines to specify Other: \_\_\_\_\_

**Allergies**  
 Patient has no known allergies  Patient has no known drug allergies  
 Aspirin  Penicillins  fentanyl  Sulfa (Sulfonamide Antibiotics)  Propofol  Versed  
 latex gloves Other: \_\_\_\_\_

**Current Medications**  
 None

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

**Immunizations**

None  
 Hep A       Hep B       Influenza vaccine       Pneumonia Vaccine  
When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_

**Diagnostic Studies/Tests**

None  
 Colonoscopy       Upper Endoscopy       Abdominal U/S       CT Abdomen w/o dye       OTHER  
When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_

**Past or Present Medical Conditions**

None  
 C.O.P.D.       Asthma       Diabetes Mellitus       GERD       Hepatitis B       Hepatitis C  
When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_  
 IBS       Liver Disease       Pacemaker       Sleep apnea       HIV       Hypertension  
When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_  
 Ischemic Heart Disease       OTHER  
When: \_\_\_\_\_ When: \_\_\_\_\_

**Previous Procedures**

None  
 Gallbladder removed       Pacemaker Atrial & Ventricular       Hysterectomy       Hernia Repair       Gastric By-Pass       OTHER  
When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_ When: \_\_\_\_\_

**Social History**

Occupation: \_\_\_\_\_ Number of Children: \_\_\_\_\_

**Marital Status**

Single       Married       Divorced       Separated       Widowed       Civil Union  
 Unknown       Other

**Alcohol**

None  
Type      Quantity      Number      Frequency  
\_\_\_\_\_

**Caffeine**

None  
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  
\_\_\_\_\_

