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Patient Interview Form

Patient Information

First Name: _____ Last Name: _____
MRN: _____ Date Of Birth: _____
Age: _____ Notes: _____

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

Ethnicity

- Hispanic or Latino Not Hispanic or Latino Patient declines to provide information

Gender

- Male Female Other

Preferred Language

- English Other: _____

Contact Preference

- Letter Telephone call e-mail Other: _____

Allergies

- Patient has no known allergies Patient has no known drug allergies
 Demerol IVP Dye Latex Penicillins Propofol
 Sulfa (Sulfonamides) Versed Other: _____ Other: _____

Immunizations

- None
 Flu Vaccine Hep B PPD/TB Skin Test Pneumonia Vaccine
When: _____ When: _____ When: _____ When: _____

Past or Present Medical Conditions

- None
- Anemia Anxiety/Depression Arthritis Atrial Fibrillation Barrett's Esophagus
- Bleeding Disorders Blood Clots (DVT) Cancer Celiac Disease Cirrhosis
- Colon Polyps Congestive Heart Failure Crohn's Disease Diabetes (Insulin Dependent) Diabetes (Non Insulin Dependent)
- Diverticulitis/Diverticulosis Gallstones GERD or reflux disease GI Bleeding Heart Attack
- Hemorrhoids Hepatitis C High Blood Pressure HIV Irritable Bowel Syndrome
- Kidney Dialysis Liver Disease Pancreatitis Pulmonary Embolism Seizure Disorder
- Stroke Ulcer Disease Ulcerative Colitis Other: _____ Other: _____

Social History

Alcohol

- None

Tobacco

Smoking Status

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

Drug Use

- None

Family Medical History

- No knowledge of family history

Health Status

Cause of Death

Diagnoses

	Mother	Father	Sister	Brother	Daughter	Son
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreas problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Review Of Systems

Constitutional <input type="radio"/> None chronic fatigue fever weight loss	Yes <input type="radio"/> No <input type="radio"/>	ENMT <input type="radio"/> None deafness dizziness mouth or throat sores hoarseness	Yes <input type="radio"/> No <input type="radio"/>	Gastrointestinal <input type="radio"/> None diarrhea constipation heartburn stomach cramps nausea vomiting blood in stool blood on the tissue paper bloating jaundice gas trouble swallowing	Yes <input type="radio"/> No <input type="radio"/>
Integumentary <input type="radio"/> None bruising rash	Yes <input type="radio"/> No <input type="radio"/>	Respiratory <input type="radio"/> None asthma wheezing cough shortness of breath	Yes <input type="radio"/> No <input type="radio"/>	Genitourinary <input type="radio"/> None increased urinary frequency change in urine color prostate problems	Yes <input type="radio"/> No <input type="radio"/>
Hematologic/Lymphatic <input type="radio"/> None anemia blood disorders easy bleeding	Yes <input type="radio"/> No <input type="radio"/>	Cardiovascular <input type="radio"/> None chest pain palpitations	Yes <input type="radio"/> No <input type="radio"/>	Neurological <input type="radio"/> None stroke numbness	Yes <input type="radio"/> No <input type="radio"/>
Musculoskeletal <input type="radio"/> None weakness back pain joint pain	Yes <input type="radio"/> No <input type="radio"/>			Psychiatric <input type="radio"/> None bad nerves depression	Yes <input type="radio"/> No <input type="radio"/>