INTERVAL INTERVIEW FORM

NAME:_____ **DOB:**_____

Who is your Primary Care doctor(PCP)? _____

Which is your preferred Pharmacy? _____ **Location:** _____

Do you have any allergies? _____

What are your current medications? _____ _____

(Name,dosage, how taken) _____ _____

_____ _____

_____ _____

What is the reason for your visit today? _____

Review Of Systems

Constitutional None_____	Yes	No
fatigue		
fever		
loss of appetite		
malaise		
sweats		
weight gain		
weight loss		

Integumentary None_____	Yes	No
allergies		
itching		
jaundice		
rash		

ENMT None_____	Yes	No
change in voice		
hearing trouble		
loss of vision		
nose bleeding		
sore throat		

Cardiovascular None_____	Yes	No
ankle swelling		
chest pain		
irregular heart beat		
shortness of breath with exertion		
trouble breathing while lying down		

Respiratory None_____	Yes	No
cough		
shortness of breath		
wheezing		

Gastrointestinal None_____	Yes	No
abdominal pain		
abdominal swelling or distention		
belching		
change in bowel habits		
constipation		
diarrhea		
flatulence		
food intolerance		
food sticking		
gas		
heartburn		
incontinence of stool		
nausea		
painful swallowing		
rectal bleeding		
stomach cramps		
trouble swallowing		
vomiting		
vomiting blood		

Genitourinary None_____	Yes	No
blood in the urine		
frequent urinary infections		
frequent urination		
uncomfortable urination		
urethral discharge or incontinence		
urination during the night		

Musculoskeletal None_____	Yes	No
back pain		
joint pain		
muscle weakness		

Neurological None_____	Yes	No
dizziness		
fainting		
frequent headaches		
migraine		
numbness or tingling		
tremors		

Psychiatric None_____	Yes	No
anxiety		
depression		
difficulty sleeping		
hallucinations		
nervousness		
panic attacks		

Endocrine None_____	Yes	No
excessive thirst		
hair loss		
heat intolerance		

Hematologic/Lymphatic None_____	Yes	No
bleeding gums		
easy bruising		
enlarged lymph nodes		
prolonged bleeding		

Allergic/Immunologic None_____	Yes	No
HIV exposure		
persisent infections		
strong allergic reactions or hives		

Since you were last seen have you had any?	Yes	No	Description
Surgery			
Non surgical Hospitilization			
New medical problems			
Worsening of prior medical problems			
blood tests			
x-rays			