Patient History Interview Form

Identify a patient for you to monitor throughout the IPPE and get the patient's history by completing this form.

General Information	
Initials:	Primary Care Provider:
Attending:	Service:

Demographic and Social Information			
DOB:	Age:	Gender: ☐ Male ☐ Female	Ethnicity:
Height:	Weight (Baseline):	Weight (Current/Measured):	
Religion Affiliation:		Occupation:	
Living Arrangement:			
Pregnant: ☐Yes ☐ No	Breastfeeding: ☐Yes ☐ No	Due date:	

*

Chief Complaint:

History of Present Illness:

Past Medical History:	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Past Surgical History:	
1.	4.
2.	5.
3.	6.

Family History		
Mother: Living: ☐ Y ☐ N	Age Deceased:	Med Hx:
Father: Living: ☐ Y ☐ N	Age Deceased:	Med Hx:
Other pertinent family Hx:		

Immunization History:	
Immunization type	Date last received
Influenza	
Tetanus	
Pneumovax	
Others:	

Patient Initials _____

Allergies (medication and food) /Adverse Reactions:	
Product name	Type and severity of reaction
1.	
2.	
3.	
4.	
5.	

Current Inpatient Medications		
Medication name, strength, regimen	Indication	Start Date
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Current Outpatient (Home) Prescription Medications		
Medication name, strength, regimen	Indication	Last Filled
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
Where do they get their prescription medications filled?		
How do they pay for their prescriptions?		

Current Outpatient (Home) Non-Prescription Medications/Herbal/Nutritional products and supplements	
Product name, strength, regimen	Indication
1.	
2.	
3.	
4.	
5.	
6.	

Assessment of Outpatient Medication Compliance
Who is responsible for medication administration for this patient? Does patient have any difficulty understanding or complying with medication instructions? Barriers to medication adherence? If yes explain:

Diet and Exercise	
Typical daily diet:	Type and frequency of exercise: Able to conduct Activities of daily living (ADL)? Yes No (explain)

Smoking, Alcohol, or Recreational Drug Use		
Smoking: Never smoked Quit smoking When: _____ How long did they smoke? ____ years Smokes _____ packs/day Exposure to second hand smoke _____ hours/day	Alcohol: No use Social use: _____/week; Quantity: _____ Regular use: _____/week; Quantity: _____	Recreational drugs: None H/O use (list agent(s), how long): Current use (list agent(s), amt, freq.):

Additional Comments or Assessments:

Medication History Preformed by: _____ Date: _____