Harford Endoscopy Center

HARFORD GASTROENTEROLOGY ASSOCIATES, P.A.
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Patient Information Form

*The following information is **very important to your health**. Please take time to completely fill out all 4 pages.*

Name_____ **DOB**_____
Primary Care Doctor _____ **Cardiologist** _____ **Ht/Wt** _____
Reason for Visit_____

Race: **O** White/Caucasian **O** Black or African American **O** Asian **O** Mixed
O American Indian Or Alaska Native **O** Native Hawaiian or other Pacific Islander **O** Other **O** Unknown **O** Patient declines to provide information

Ethnicity: **O** Hispanic/Latino **O** Not Hispanic/Latino **O** Patient declines to provide information
Preferred Language: **O** English **O** Korean **O** Spanish **O** Other: _____

→ **Do you have any of the following allergies**: **O** Latex **O** Penicillin **O** Eggs **O** Soy **O** Sulfa
→ **Do you have any other drug or food allergies: O** No **O** Yes **(Please List Name and Reaction Type)**

Pharmacy Name, Location, and Zip Code: _____

Consent to obtain a history of medications purchased at Pharmacies **O** Yes **O** No

Current Medications (Please fill out completely, *if more space is needed please use page 4*) **O** None

MEDICATION	DOSE (MG or MCG etc.)	FREQUENCY (HOW OFTEN, HOW MANY)

Patient Initials:_____ Staff Reviewer:_____ Date: _____

Patient Name: _____ DOB: _____

→ **Have you had any of the following immunizations**: **O** Hepatitis A When: _____ **O** Hepatitis B When: _____ **O** Pneumovax When: ____

O Flu Vaccine When: _____ **O** HPV When: _____ **O** Herpes Zoster When: _____

→ **Have you had any of the following Diagnostic Studies done:**

O None
O CT Scan of Abdomen/Pelvis, When: _____
O Abdominal Ultrasound, When: _____
O Camera Pill Examination, When: _____
O Endoscopy, When: _____
O Colonoscopy, When: _____
O ERCP, When: _____
O Other (list): _____

→**Wellness Maintenance:** Date of Last: Dermatology Consult: _____ Pap Smear**:** _____

→ **In the Past Six months have you had a stroke?**	**O** No	**O** Yes
→ **In the Past Three months have you had a seizure?**	**O** No	**O** Yes
→ **In the Past Three months have you had a heart attack?**	**O** No	**O** Yes
→ **Do you have a history of life-threatening anesthesia complications?**	**O** No	**O** Yes
→ **Do you use oxygen?**	**O** No	**O** Yes
→ **Do you receive Kidney Dialysis?**	**O** No	**O** Yes
→ **Have you had an Organ Transplant?**	**O** No	**O** Yes
→ **Weigh Greater than 350lbs?**	**O** No	**O** Yes
→ **Personal or Family History of Malignant Hyperthermia?**	**O** No	**O** Yes
→ **History of Pulmonary Hypertension (Lung Disease)?**	**O** No	**O** Yes

→ **Do you take any of these Medications?** **O** Not Currently Using blood thinners **O** Coumadin **O** Aspirin **O** Plavix **O** Pradaxa **O** Xarelto **O** Eliquis

→ **Do you have one of the following?** **O** Pacemaker **O** Defibrillator

→ **Have you ever had anesthesia?**	**O** No	**O** Yes
→ **Any *Non-Life*-Threatening reactions to anesthesia?**	**O** No	**O** Yes

→ **Do you have a history of the following?** **O** Tracheostomy **O** C-PAP Use

→ **Females Only Anesthesia Screening**

Current Birth Control Use:

O Birth Control Pills
O Birth Control Patch
O NuvaRing
O IUD use
O Hormonal implant
O Deposhot Use
O Diaphragm/Condom
O Tubal Ligation
O Hysterectomy
O Post-Menopausal
O History of Uterine Ablation
O Not currently using birth control

Patient Initials:_____ Staff Reviewer:_____ Date: _____

Patient Name: _____ DOB: _____

→ Do you have a history of any of the following conditions? **O** None

O Abnormal Liver Tests
O Barrett's Esophagus
O Cirrhosis
O Colon Polyps
O Diverticulosis
O Gallstones
O GI Bleeding
O Hepatitis B
O Liver Disease
O Ulcer Disease
O Anemia
O Celiac Sprue
O Colon Cancer
O Crohn's Disease
O GI Cancer
O Acid Reflux
O Hemorrhoids
O Hepatitis C
O Pancreatitis
O Ulcerative Colitis
O Other_____

→ Do you have any of the following heart conditions? **O** None

O Coronary artery disease
O History of Heart Attack
O Heart Surgery
O Heart Stents
O Heart Valve Replacement
O Aortic Stenosis
O History of Bacterial Endocarditis
O Congestive Heart Failure
O Other Heart problems:
_____
_____
O Atrial Fibrillation

→ Do you have any lung problems? **O No** **O Yes**

O Asthma
O COPD
O Other Lung problems:
O Emphysema
O Sleep Apnea
(list)_____

→ Do you have diabetes? **O** No **O** Yes

O On oral medication
O On insulin
O Diet Controlled

→ Do you have any of the following conditions? **O** None

O Arthritis
O Hypertension
O High Cholesterol
O Thyroid Disorder
O Glaucoma
O Seizures
O Kidney Problems
O Endometriosis
O Lung Cancer
O Prostate Cancer
O Breast Cancer
O Gynecological Cancer
O Blood Clots (DVT)
O History of Blood Transfusions
O Other_____
_____

→ Surgical History: Have you had any of the following surgeries? **O** None

O Gallbladder Surgery
O Hemorrhoid Surgery
O Prostate Surgery
O Colon Resection
O Hernia Repair
O Joint Replacement
O Gastric By-Pass
O C-Section
O Other Major Surgeries (list)_____
O Appendix Surgery
O Hysterectomy
_____
_____

Occupation: _____ **Number of Children**_____

Marital Status: **O** Single **O** Married **O** Divorced **O** Separated **O** Widowed **O** Civil Union

I use tobacco: **O** Yes **O** No (circle) Cigarettes Pipe Cigars Chew Packs Per Day___ No. Years__ I quit smoking____years/ months ago	**I drink alcohol:** **O** Yes **O** No ____per day ____per week	**Caffeine**:(coffee, tea, cola): ___Cups per day	**Recreational or street drugs in the past?** **O** Yes **O** No **Recreational or street drugs now?** **O** Yes **O** No **History of IV (intravenous) drug use?** **O** Yes **O** No

Patient Initials:_____ Staff Reviewer:_____ Date: _____

Patient Name: _____ DOB: _____

→ Have you had any of these symptoms *IN THE PAST SIX MONTHS*? (Mark those that apply)

ENMT
- O Glaucoma
- O Difficulty swallowing
- O Hoarseness
- O Mouth sores
- O Sore throat

ALLERGIC/IMMUNOLOGIC
- O HIV Exposure
- O Food Allergy

CARDIOVASCULAR
- O Murmur
- O Chest pain
- O Swelling of legs
- O Irregular heart
- O High blood pressure

CONSTITUTIONAL
- O Fatigue
- O Loss of appetite
- O Weight gain
- O Weight loss
- O Fever

ENDOCRINE
- O Diabetes
- O Hyper/hypothyroidism

GASTROINTESTINAL
- O Indigestion
- O Peptic ulcer disease
- O Hepatitis
- O Gall bladder disease
- O Pancreatitis
- O Diarrhea
- O Constipation
- O Rectal bleeding
- O Nausea
- O Vomiting
- O Food intolerance
- O Swallowing pain
- O Abdominal pain
- O Abdominal swelling
- O Change in bowel habits
- O Gas
- O Heartburn
- O Jaundice(yellowing of skin)

GENITOURINARY
- O Kidney Stones
- O Dark Urine
- O Hematuria

HEMATOLOGIC/LYMPHATIC
- O Anemia
- O Bleeding disorder
- O Blood Transfusion
- O Clots
- O Aneurysm

INTEGUMENTARY
- O Hives
- O Rashes
- O Itching
- O Jaundice

MUSCULOSKELETAL
- O Arthritis
- O Gout

NEUROLOGICAL
- O Seizures
- O Stroke
- O Mini-Stroke
- O Frequent Headaches
- O Migraine

PYSCHIATRIC
- O Anxiety
- O Depression
- O Hallucinations/Paranoia
- O Suicidal thoughts
- O Panic Attacks

RESPIRATORY
- O Pneumonia
- O Asthma
- O Chronic cough
- O Coughing up blood
- O Positive TB skin test or TB exposure
- O Shortness of breath

→ Family Medical History:

O No Knowledge of family history (adopted).

Is there any family history of…?

Colon polyp	O No	O Yes (who?)_____
Colon Cancer	O No	O Yes (who?)_____
Crohns Disease	O No	O Yes (who?)_____
Liver Disease or Hepatitis	O No	O Yes (who?)_____
Ulcerative Colitis	O No	O Yes (who?)_____
GI Cancer (stomach, liver biliary, pancreas)	O No	O Yes (who?)_____
Celiac Sprue	O No	O Yes (who?)_____

Patient/Parent/Guardian/ Signature Date

Staff Reviewer:_____ Date: _____

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PATIENT DEMOGRAPHIC INFORMATION

NAME_____ SS #_____-_____-_____
LAST FIRST MI

ADDRESS_____ APT_____ DATE OF BIRTH ____-____-_____

CITY _____ STATE_____ ZIP CODE _____ MARITAL STATUS: □ S □ M

HOME PHONE_____ WORK PHONE_____ □ D □ W

CELL PHONE_____ EMAIL_____ SEX: □ Male □ Female

EMPLOYER_____ DRUG ALLERGIES: _____
(If retired-give name of company)

REFERRING PHYSICAN_____

ADDRESS/PHONE_____

WHOM TO NOTIFY IN CASE OF EMERGENCY

NAME_____ RELATIONSHIP_____

CELL PHONE_____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NAME_____ RELATIONSHIP_____

CELL PHONE_____

ETHNICITY

Please Check off the following. This information is requested by the Department of Health and Mental Hygiene, for Statistical reporting purposes only.

☐ 1. African American ☐ 2. American Indian/Eskimo ☐ 3. Asian ☐ 4. Hispanic ☐ 5. Pacific Islander ☐ 6. Caucasian ☐ 7. Other

PRIMARY INSURANCE_____ ADDRESS_____

POLICY HOLDER _____ SS #_____-_____-_____

DATE OF BIRTH_____ POLICY#_____ GROUP#_____

EMPLOYER_____

SECONDARY INSURANCE_____ ADDRESS_____

POLICY HOLDER _____ SS #_____-_____-_____

DATE OF BIRTH_____ POLICY#_____ GROUP#_____

EMPLOYER_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize release of any medical information necessary to process any insurance claims and authorize payment of medical benefits directly to HARFORD GASTROENTERLOGY ASSOCIATES, P.A./HARFORD ENDOSCOPY CENTER for myself or my dependents. I understand that I am responsible for any Deductibles, Co-Insurance, Co-pays, or other amounts not covered by my insurance companies. If a referral is required and is not presented at time of service, service will be denied until the referral is obtained.

EMAIL/TEXT/AUTOMATED COMMUNICATION INFORMED CONSENT

I hereby consent and authorize Harford Endoscopy Center, any associated physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, billing services, debt collectors, and other contracted parties, to use automated telephone dialing systems, text messaging systems, and electronic mail to provide messages (including pre-recorded or synthetic messages, text messages and voicemail messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, health care coverage, care follow-up, and other healthcare information.

DATE_____ SIGNATURE_____

CONFIRMATION OF PATIENT INFORMATION ON DAY OF PROCEDURE

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

DATE_____ SIGNATURE_____