Harford Endoscopy Center

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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_____ **Height/Weight** _____
Reason for Visit_____

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

Preferred Language: **O** English **O** Korean **O** Spanish **O** Other: _____

Ethnicity: **O** Hispanic/Latino **O** Not Hispanic/Latino **O** Patient declines to provide information

→ **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) **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 Three months have you had a stroke?**	**O** No	**O** Yes When: _____
→ **In the Past Three months have you had a seizure?**	**O** No	**O** Yes When: _____
→ **In the Past Three months have you had a heart attack?**	**O** No	**O** Yes When: _____
→ **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 a Pacemaker?** **O** No **O** Yes, if yes, **Date last checked and name of Cardiologist**: _____
_____

→ **Do you have a Defibrillator?** **O** No **O** Yes, if yes, **Date last checked and name of Cardiologist**: _____
_____

→ **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 a Tracheostomy?**	**O** No	**O** Yes
→ **Do you use a CPAP machine?**	**O** No	**O** Yes

→ **Females Only Anesthesia Screening**

Current Birth Control Use:

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

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

→ 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 Are you adopted? **O** No **O** Yes

Is there any family history of…?

Colon polyp	**O** No	**O** Yes (who?) _____	If Deceased, age_____
Colon Cancer	**O** No	**O** Yes (who?) _____	If Deceased, age_____
Crohn's Disease	**O** No	**O** Yes (who?) _____	If Deceased, age_____
GI Cancer (stomach, liver, pancreas)	**O** No	**O** Yes (who?) _____	If Deceased, age_____
Ulcerative Colitis	**O** No	**O** Yes (who?) _____	If Deceased, age_____
Liver Disease or Hepatitis	**O** No	**O** Yes (who?) _____	If Deceased, age_____
Celiac Sprue	**O** No	**O** Yes (who?) _____	If Deceased, age_____

_____

Patient/Parent/Guardian/ Signature Date

Staff reviewer:_____ Date: _____