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|  | **2214 Old Emmorton Rd, Suite 100**  **Bel Air, MD 21015**  **Ph.: (410) 838-6345 Fax: 410-838-1595** |  |

**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: О** White/Caucasian **О** Black or African  **О** Asian **О** American Indian **О** Native Hawaiian

AmericanOr Alaska Native or other Pacific

**О** Unknown **О** Patient declines to Islander

provide information

**Preferred Language: О** English **О** Korean **О** Spanish **О** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**→ Do you have any of the following allergies**: **О** Latex **О** Penicillin **О** Eggs **О** Soy **О** Sulfa

**→ Do you have any other drug or food allergies: О** No **О** Yes **(Please List Name and Reaction Type)**

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**Pharmacy Name, Location, and Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

­­­**Current Medications (Please fill out completely)** **О** None

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

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Patient Initials: \_\_\_\_\_\_\_\_ Staff Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**→ Have you had any of the following immunizations**: **О** Hepatitis A **О** Hepatitis B **О** Pneumovax

When: \_\_\_\_\_\_\_ When: \_\_\_\_\_\_\_ When: \_\_\_\_

**О** Flu Vaccine **О** HPV **О** Herpes Zoster **О** Covid-19 Dose 1 **О** Covid-19 Dose 2

When: \_\_\_\_\_\_\_ When: \_\_\_\_\_\_\_ When: \_\_\_\_\_\_\_\_ When: \_\_\_\_\_\_\_\_ When: \_\_\_\_\_\_\_\_

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

**О** None **О** Endoscopy, When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **О** CT Scan of Abdomen/Pelvis, When: \_\_\_\_\_\_\_\_ **О** Colonoscopy, When: \_\_\_\_\_\_\_\_\_\_\_\_

**О** Abdominal Ultrasound, When: \_\_\_\_\_\_\_\_\_\_\_\_ **О** ERCP, When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**О** Camera Pill Examination, When: \_\_\_\_\_\_\_\_\_\_\_ **О** Other (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**→Wellness Maintenance:** Date of Last: Dermatology Consult: \_\_\_\_\_\_\_\_\_\_Pap Smear**:** \_\_\_\_\_\_\_\_\_\_\_\_

**→ In the Past Three months have you had a stroke?** **О** No **О** Yes When: \_\_\_\_\_\_

**→ In the Past Three months have you had a seizure?** **О** No **О** Yes When: \_\_\_\_\_\_

**→ In the Past Three months have you had a heart attack?** **О** No **О** Yes When: \_\_\_\_\_\_

**→ Do you have a history of life-threatening anesthesia complications?** **О** No **О** Yes

**→ Do you use oxygen?** **О** No **О** Yes

**→ Do you receive Kidney Dialysis?** **О** No **О** Yes

**→ Have you had an Organ Transplant?** **О** No **О** Yes

**→ Weigh Greater than 350lbs? О** No **О** Yes

**→ Personal or Family History of Malignant Hyperthermia? О** No **О** Yes

**→History of Pulmonary Hypertension (Lung Disease)? О** No **О** Yes

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

**О** Xarelto **О** Eliquis

**→ Do you have a Pacemaker?** **О** No **О** Yes, if yes, **Date last checked and name of Cardiologist**: \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**→ Have you ever had anesthesia?** **О** No **О** Yes

**→ Any *Non-Life*-Threatening reactions to anesthesia? О** No **О** Yes

**→ Do you have a history of a Tracheostomy?** **О** No **О** Yes

**→ Do you use a CPAP machine? О** No **О** Yes

**→ Females Only Anesthesia Screening**

**Current Birth Control Use: О** Birth Control Pills **О** Birth Control Patch

**О** NuvaRing **О** IUD

**О** Hormonal implant **О** Depo Provera

**О** Diaphragm/Condom **О** Tubal Ligation

**О** Hysterectomy **О** Post-Menopausal

**О** History of Uterine **О** Not currently using

Ablation birth control

Patient Initials: \_\_\_\_\_\_\_\_ Staff Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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| **О** Abnormal Liver Tests  **О** Barrett’s Esophagus  **О** Cirrhosis  **О** Colon Polyps  **О** Diverticulosis  **О** Gallstones  **О** GI Bleeding  **О** Hepatitis B  **О** Liver Disease  **О** Ulcer Disease | **О** Anemia  **О** Celiac Sprue  **О** Colon Cancer  **О** Crohn’s Disease  **О** GI Cancer  **О** Acid Reflux  **О** Hemorrhoids  **О** Hepatitis C  **О** Pancreatitis  **О** Ulcerative Colitis  **О** Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **О** Coronary artery disease  **О** History of Heart Attack  **О** Heart Surgery  **О** Heart Stents  **О** Heart Valve Replacement  **О** Aortic Stenosis  **О** History of Bacterial Endocarditis  **О** Congestive Heart Failure  **О** Atrial Fibrillation  **О** Other Heart problems:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | When: \_\_\_\_\_\_  When: \_\_\_\_\_\_  When: \_\_\_\_\_\_  When: \_\_\_\_\_\_  When: \_\_\_\_\_\_  When: \_\_\_\_\_\_  When: \_\_\_\_\_\_  When: \_\_\_\_\_\_  When: \_\_\_\_\_\_  When: \_\_\_\_\_\_  When: \_\_\_\_\_\_  When: \_\_\_\_\_\_ |
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**→ Do you have any lung problems? О No О Yes → Do you have diabetes? О** No **О** Yes

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| **О** Asthma  **О**  COPD  **О** Other Lung problems: | **О** Emphysema  **О** Sleep Apnea  (list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **О** On oral medication  **О** On insulin  **О** Diet Controlled |  |

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

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| **О** Arthritis  **О** Hypertension  **О** High Cholesterol  **О** Thyroid Disorder | **О** Glaucoma  **О** Seizures  **О** Kidney Problems  **О** Endometriosis | **О** Lung Cancer  **О** Prostate Cancer  **О** Breast Cancer  **О** Gynecological Cancer | **О** Blood Clots (DVT)  **О** History of Blood  Transfusions  **О** Other\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

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| **О** Gallbladder Surgery  **О** Hemorrhoid Surgery  **О** Prostate Surgery | **О** Colon Resection  **О** Hernia Repair  **О** Joint Replacement | **О** Gastric By-Pass  **О** C-Section  **О** Other Major Surgeries (list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **О** Appendix Surgery  **О** Hysterectomy  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Number of Children**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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| **I use tobacco:** **О** Yes **О** No  (circle) Cigarettes Pipe Cigars Chew  Packs Per Day\_\_\_ No. Years\_\_  I quit smoking\_\_\_\_years/ months ago | **I drink alcohol:**  **О** Yes **О** No  \_\_\_\_per day  \_\_\_\_per week | **Caffeine**:(coffee, tea, cola): \_\_\_Cups per day | **Recreational or street drugs in the past?**  **О** Yes **О** No  **Recreational or street drugs now?** **О** Yes **О** No  **History of IV (intravenous) drug use?** **О** Yes **О** No |

Patient Initials: \_\_\_\_\_\_\_\_ Staff Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

→ **Have you had any of these symptoms *in the past six months*? (Mark those that apply)**

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| **ENMT**  **О** Glaucoma  **О** Difficulty swallowing  **О** Hoarseness  **О** Mouth sores  **О** Sore throat  **ALLERGIC/IMMUNOLOGIC**  **О** HIV Exposure  **О** Food Allergy  **CARDIOVASCULAR**  **О** Murmur  **О** Chest pain  **О** Swelling of legs  **О** Irregular heart  **О** High blood pressure  **CONSTITUTIONAL**  **О** Fatigue  **О** Loss of appetite  **О** Weight gain  **О** Weight loss  **О** Fever  **ENDOCRINE**  **О** Diabetes  **О** Hyper/hypothyroidism | **GASTROINTESTINAL**  **О** Indigestion  **О** Peptic ulcer disease  **О** Hepatitis  **О** Gall bladder disease  **О** Pancreatitis  **О** Diarrhea  **О** Constipation  **О** Rectal bleeding  **О** Nausea  **О** Vomiting  **О** Food intolerance  **О** Swallowing pain  **О**  Abdominal pain  **О** Abdominal swelling  **О** Change in bowel habits  **О** Gas  **О** Heartburn  **О** Jaundice(yellowing of skin)  **GENITOURINARY**  **О** Kidney Stones  **О** Dark Urine  **О** Hematuria  **HEMATOLOGIC/LYMPHATIC**  **О** Anemia  **О** Bleeding disorder  **О** Blood Transfusion  **О** Clots  **О** Aneurysm | **INTEGUMENTARY**  **О** Hives  **О** Rashes  **О** Itching  **О** Jaundice  **MUSCULOSKELETAL**  **О** Arthritis  **О** Gout  **NEUROLOGICAL**  **О** Seizures  **О** Stroke  **О** Mini-Stroke  **О** Frequent Headaches  **О** Migraine  **PYSCHIATRIC**  **О** Anxiety  **О** Depression  **О** Hallucinations/Paranoia  **О** Suicidal thoughts  **О** Panic Attacks  **RESPIRATORY**  **О** Pneumonia  **О** Asthma  **О** Chronic cough  **О** Coughing up blood  **О** Positive TB skin test or TB exposure  **О** Shortness of breath |

**→ Family Medical History:**

**О** No Knowledge of family history Are you adopted? **О** No **О** Yes

Is there any family history of…?

Colon polyp **О** No **О** Yes (who?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If Deceased, age\_\_\_\_\_\_

Colon Cancer **О** No **О** Yes (who?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If Deceased, age\_\_\_\_\_\_

Crohn’s Disease **О** No **О** Yes (who?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If Deceased, age\_\_\_\_\_\_

GI Cancer (stomach, liver, pancreas) **О** No **О** Yes (who?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If Deceased, age\_\_\_\_\_\_

Ulcerative Colitis **О** No **О** Yes (who?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If Deceased, age\_\_\_\_\_\_

Liver Disease or Hepatitis **О** No **О** Yes (who?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If Deceased, age\_\_\_\_\_\_

Celiac Sprue **О** No **О** Yes (who?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If Deceased, age\_\_\_\_\_\_

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| Patient/Parent/Guardian/ Signature | Date |

Staff Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_