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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 ChewPacks 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_