Harford Endoscopy Center

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: **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 Name: _____ DOB: _____

Patient Initials: _____ Staff Reviewer: _____ Date: _____

→ **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: _____ **O** Covid-19 Dose 1 When: _____ **O** Covid-19 Dose 2 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
O Depo Provera
O Tubal Ligation
O Post-Menopausal
O Not currently using birth control

Patient Name: _____ DOB: _____

Patient Initials: _____ Staff Reviewer: _____ Date: _____

→ 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 Name: _____ DOB: _____

Patient Initials: _____ Staff Reviewer: _____ Date: _____

→ 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: _____

Harford Endoscopy Center

2214 Old Emmorton Rd, Suite 100
Bel Air, MD 21015 (410) 838-6345

PATIENT DEMOGRAPHIC INFORMATION

NAME_____ SS #_____-_____-_____
LAST FIRST MI

ADDRESS_____ APT_____ DATE OF BIRTH ____-____-_____

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

HOME PHONE_____ WORK PHONE_____

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_____

POLICY HOLDER _____ SS #_____-_____-_____

DATE OF BIRTH_____ POLICY#_____ GROUP#_____

EMPLOYER_____

SECONDARY INSURANCE_____

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_____