

Patient Name: _____

DOB: _____

- Have you had any of the following immunizations:
- Hepatitis A
 - Hepatitis B
 - Pneumovax
- When: _____ When: _____ When: _____
- Flu Vaccine
 - HPV
 - Herpes Zoster
 - Covid-19 Dose 1
 - Covid-19 Dose 2
 - Covid-19 Booster
- When: _____ When: _____ When: _____ When: _____ When: _____ When: _____

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

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

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

- Have you ever had anesthesia? No Yes
- Have you had a severe reaction to anesthesia? No Yes
- Do you have a history of a Tracheostomy? No Yes
- Do you use a CPAP machine? No Yes
- Do you have Central Sleep Apnea? (not Obstructive Sleep Apnea) No Yes

- In the Past Three (3) months have you had a stroke? No Yes When: _____
- In the Past Three (3) months have you had a seizure? No Yes When: _____
- In the Past Six (6) months have you had a heart attack/stents? No Yes When: _____
- Do you use oxygen? No Yes
- Do you receive Kidney Dialysis? No Yes
- Have you had an Organ Transplant? No Yes
- Weigh Greater than 350lbs? No Yes
- Weigh less than 80lbs? No Yes
- History of Severe Pulmonary Hypertension (lung disease: not high blood pressure?) No Yes
- Are you able to walk independently? No Yes
- Do you have Sickle Cell Disease? No Yes
- Do you have a genetic disorder such as Down Syndrome, Treacher Collins Syndrome, or Pierre Robin Syndrome? No Yes
- Do you have Chiari Malformation? No Yes

→ Do you take any of these Medications? Not taking any blood thinners Coumadin Aspirin Plavix Pradaxa Xarelto Eliquis

→ Do you have a Defibrillator? No Yes, if yes, Date last checked: _____
→ Do you have a Pacemaker? No Yes, if yes, Date last checked: _____

→ Females Only Anesthesia Screening
Current Birth Control Use:

- Tubal Ligation
- Postmenopausal > 2 years
- Hysterectomy

Please note: If you will be scheduled for a procedure, a urine specimen will be collected day of your procedure.

Staff Reviewer: _____

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

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

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

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

→ Do you have any lung problems? No Yes

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

→ Do you have diabetes? No Yes

- On oral medication
- On insulin
- Diet Controlled

→ Do you have any of the following conditions? None

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

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

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

I use tobacco: <input type="radio"/> Yes <input type="radio"/> No (circle) Cigarettes Pipe Cigars Chew Vape (Smokeless) Packs Per Day ___ No. Years ___ I quit smoking ___ years/ months ago	I drink alcohol: <input type="radio"/> Yes <input type="radio"/> No ___ per day ___ per week	Caffeine: (coffee, tea, cola): ___Cups per day	Recreational or street drugs in the past? <input type="radio"/> Yes <input type="radio"/> No Recreational or street drugs now? <input type="radio"/> Yes <input type="radio"/> No History of IV (intravenous) drug use? <input type="radio"/> Yes <input type="radio"/> No Medical Marijuana Use? <input type="radio"/> Yes <input type="radio"/> No
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→ Have you had any of these symptoms **IN THE PAST SIX MONTHS?** (Mark those that apply)

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

No Knowledge of family history

Are you adopted? No Yes

Is there any family history of...?

- | | | | |
|--------------------------------------|--------------------------|--|------------------------|
| Colon polyp | <input type="radio"/> No | <input type="radio"/> Yes (who?) _____ | If Deceased, age _____ |
| Colon Cancer | <input type="radio"/> No | <input type="radio"/> Yes (who?) _____ | If Deceased, age _____ |
| Crohn's Disease | <input type="radio"/> No | <input type="radio"/> Yes (who?) _____ | If Deceased, age _____ |
| GI Cancer (stomach, liver, pancreas) | <input type="radio"/> No | <input type="radio"/> Yes (who?) _____ | If Deceased, age _____ |
| Ulcerative Colitis | <input type="radio"/> No | <input type="radio"/> Yes (who?) _____ | If Deceased, age _____ |
| Liver Disease or Hepatitis | <input type="radio"/> No | <input type="radio"/> Yes (who?) _____ | If Deceased, age _____ |
| Celiac Sprue | <input type="radio"/> No | <input type="radio"/> Yes (who?) _____ | If Deceased, age _____ |

Patient/Parent/Guardian/ Signature

Date

Staff Reviewer: _____

Date: _____



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 PHYSICIAN _____

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 GASTROENTEROLOGY 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 _____