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Bel Air, MD 21015 (410) 838-6345

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

Ethnicity: **O** Hispanic/Latino **O** Not Hispanic/Latino **O** Patient declines to provide information
Preferred Language: **O** English **O** Korean **O** Spanish **O** Other: ________________________

→ **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 Reason 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 Initials:________ Staff Reviewer:______________________________ Date: ____________________

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: ______ When: ______
O Aortic Stenosis When: ______
O History of Bacterial Endocarditis When: ______ 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…?

Condition	No	Yes (who?)	If Deceased, age
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: _____________________