Harford Gastroenterology Associates

Weitong Mu, MD, PhD
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Peter D. Park, MD
Asheesh Sood, MD
Subramanian Srinivas, MD
Veda Viswanathan, MD, FRCP, FACP, FACG, AGAF

Kathleen Bocskor, FNP
Kayla Bynion, PA-C
Heather Rosario, PA-C

Thomas A. Huebner, MD
Pathologist

Dear new patient,

Welcome to our practice! We are here to help you. Please do not hesitate to call us. We strive to provide you with the highest standard of medical care and excellent service. We want you to feel comfortable and pleased with the care we provide to you.

You are scheduled to see _____on (date) _____at (time) _____.

Attached to this letter are the following forms. Please complete these forms and bring them with you to your appointment.

- Patient Demographic Form
- Patient Financial Agreement
- Patient Financial Responsibility Notice For Scheduled Procedures
- Notice of Privacy Practices
- Authorization for Use and Release of Information
- HIPAA-Compliant Authorization to Release Medical Records
- Complete Patient History Form

We use the information you provide to ensure that we record a thorough and completed medical history and comprehensive medical examination. The information you provide is very important. Please be sure to provide completed information to us.

There are a few additional items you will need to bring to each of your appointments. Please be sure to bring:

- Legal picture ID such as a passport or state driver's license
- Insurance cards
- Referral from your Primary Care Physician or insurance carrier
- Co-pay

If you are registering by mail, please send clear photocopies of your picture ID and both sides of all insurance cards to the address listed below. We scan that information to your medical record. We will use it to verify your insurance coverage for procedures and office visits. We will check your picture ID and update insurance information at each visit.

All new patients will need to bring a referral to see your new GI specialist. With your permission, we will help you acquire your referral. Once we receive the referral, we will confirm the date and time of your first appointment. Some insurance products do not require referrals. We will be able to make that determination once we have a copy of your insurance card.

The amount of your co-pay to see a specialist is stated on the front of many insurance cards. If you are unsure about your co-pay, you may call your insurance carrier to inquire for details. We are available to help you with this information too.

Our clinical staff will use your medication bottles to perform a thorough review of your medications at each and every office visit. Please be sure to share complete information with us about all your medications.

We look forward to meeting you in person and learning how we can help you. Thank you for choosing Harford Gastroenterology Associates for your GI specialty care.

Sincerely,
Harford Gastroenterology Associates and Staff

Harford Gastroenterology Associates

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PATIENT DEMOGRAPHIC INFORMATION

First Name: _____ MI: _____ Last Name: _____
Date of Birth: _____ Gender: M/F Social Security #: _____-_____-_____
Street Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Work Phone #: _____Cell Phone #: _____
Email Address: _____ Employer: _____
Referring Physician: _____
Pharmacy Name, Phone, & Address: _____
Emergency Contact: _____ Phone #: _____ Relationship: _____

PRIMARY INSURANCE

Carrier: _____ Policy #: _____
Phone: _____ Group#: _____
Address: _____ Effective Date: _____
Subscriber: _____ Subscriber DOB: _____
Subscriber Employer: _____

SECONDARY INSURANCE

Carrier: _____ Policy #: _____
Phone: _____ Group#: _____
Address: _____ Effective Date: _____
Subscriber: _____ Subscriber DOB: _____
Subscriber Employer: _____

Signature: _____ **Date:** _____

Version 4/04/2022

Harford Gastroenterology Associates

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Consent to Treat, Disclosure & Assignment of Benefits

I understand that as part of my healthcare, this practice creates and maintains a health record describing my health history. I understand that this practice may use this information as:

1. A basis for planning my care and treatment.
2. A means of communication among many health professionals who contribute to my care.
3. A means by which third party payors can verify that services billed were actually provided.
4. A tool for routing healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
5. A means by which licensing, accreditation, and regulatory agencies can verify that appropriate quality services were provided.

I consent to treatment at this practice under the care of the medical staff, their associates, partners, or designees. I consent to any or all outpatient care, which encompasses the following as ordered by my physician: interview, physical examination, x-ray examination or fluoroscopy, laboratory procedures, diagnostic procedures, conscious sedation, general and/or local anesthesia, and nursing or medical treatment which my physician may deem necessary or advisable.

I consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations.

I authorize this practice to apply for benefits on my behalf for my covered services. I request payment from insurance company to be made directly to Harford Gastroenterology Associates, P.A.

I understand that I am responsible for any deductibles, co-insurance, co-pays or other amounts not covered by my insurance carrier. If a referral is required and is not presented at time of service, service will be denied until the referral is obtained.

Signature:_____ Date: _____

Version 4/27/2021

Harford Gastroenterology Associates

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PATIENT FINANCIAL AGREEMENT

Understanding our financial policies is an important part of your overall experience with our office and staff. Feel free to ask any questions you may have about this financial agreement. Please read these policies carefully and sign below, indicating that you have read and understand the policies detailed within. If you do have questions, please feel free to ask our Billing Manager 443-643-4700 ex 140 or option 6.

INSURANCE PARTICIPATION

We are participating providers for various insurance carriers and we accept all insurance coverage payments. Our office will do our very best to verify your benefits related to your services with our office, our verification is only a preliminary cost until your insurance carrier processes the services.

OUR RESPONSIBILITY TO YOU:

1. To keep up-to-date records of your insurance coverage.
2. To submit medical claims to your insurance carrier on your behalf and to make appropriate appeals when claims are initially denied by your insurance carrier.
3. To help you understand the specific details of your insurance coverage for services rendered by our providers.
4. Advise you of any referral or pre-auth that maybe needed for your services with HGA.
5. Pre-Authorization maybe be required by your insurance plan, our internal specialist staff will communicate your financial obligations via mail or telephone.

YOUR RESPONSIBILITY TO OUR OFFICE:

1. Provide accurate and up-to-date demographic and insurance information to our office. Failure to provide us with this information may lead to denial of claims and cause you to be personally responsible for charges incurred.
2. Referrals maybe required for a specialist – HGA must have a referral prior to your appointment;
    a. If a referral is not received by your PCP (primary care physician) you may have to reschedule.
3. Accountable for any out-of-pocket expenses that are owed as dictated by your insurance coverage.
    a. Co-payments, Co-insurances and Deductibles are due at the time of service
    b. Past due balances are due at day of appointment with check in or prior to your appointment date

CREDIT BALANCES or OVERPAYMENTS

1. Our Billing Department reconciles all account activities by date of service and will apply current credits to your owed balance, open scheduled appointments or prepare your account for a refund via check.
    a. Inactive accounts with credit balances will be refunded by check unless specified.
    b. Unclaimed refund checks – after 3 years
        i. Contact Comptroller of Maryland – unclaimed property

ACCOUNT RECEIVABLE

1. Non-payment received for open account balances after 120 days
    a. Will be forwarded to our Collection Agency RMP
    b. Accounts in Collections and or Collection Status – must be paid prior to receiving an appointment
2. Returned checks for payments – due to non-sufficient funds or closed bank accounts
    a. Will incur a $ 35.00 fee
3. Missed appointment no call within 24 hours – No Show Fee $25.00

I have read and agree to Harford Gastroenterology Associates, PA polices listed above, and your signature acknowledges HGA has shared our internal standard work processes with hopes of giving you a better understanding of financial policies.

_____ _____

Signature Date

_____ _____

Printed Name Patient DOB 4/7/2022

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Patient Financial Responsibility Notice
For Scheduled Procedures

The purpose of this document is to inform the patient that after we submit the medical claim to your insurance company, you will receive multiple bills for the services associated with your procedure, as follows:

1. **Physician Fees**: **Harford Gastroenterology Associates, P.A**. 443.643.4700 option 6. This bill includes the physician's charges for performing procedure. The patient is responsible for paying: co-payment, co-insurance and insurance deductible. This is the amount we will collect from you before the date of your procedure and after, if deemed by your insurance.

2. **Facility Fees: Harford Endoscopy Center** 1.844.235.0194. This bill includes the charges associated with the use of the operating room facility, medical equipment, standard supplies, medications and nursing care. This facility is licensed by the State of Maryland and certified by Medicare as an Ambulatory Surgery Center. Please be prepared to pay your facility co-payment, co-insurance and deductible on or before the date of your procedure.

3. **Sedation/Anesthesia Fees: Bel Air Sedation** 1.800.222.1442. This bill includes the charges of anesthesia for your procedure. An insurance claim will be submitted to your insurance carrier on your behalf.

4. **Laboratory Fees:** You should expect to receive two invoices for laboratory fees.
    a. Harford Gastroenterology Associates, Pathology Lab 443.643.4700, option 6, this charge is for processing the biopsy specimen. AND/OR
    b. Integrated Cellular and Molecular Diagnostics at 1.844.522.4263 ext. 102.

5. **No Show Fees:** Patients should make every effort to attend this appointment. Please notify us at least 48 hours in advanced of a schedule change. Failure to give 48 hours' notice of appointment cancelation will result in a $100 No Show Fee from Harford Endoscopy Center.

Please remember. The patient is responsible for payment of any unmet deductible, co-insurance and co-payment. It is the patient's responsibility to contact his/her insurance carrier to verify benefits and coverage limits for each procedure. Please take the time to help yourself by contacting your insurance carrier before the date of your procedure.

Any discrepancies with your billing including over-payments made by you, please call the associated companies to address your concerns. We thank you for your services and look forward to a continued healthy future together.

I, _____ (patient's printed first and last name and Account #) acknowledge receipt of this notice and signify that by signing the notice, I understand my financial responsibility and I understand that I will receive multiple invoices for services related to my surgical procedure.

Patient Signature Date Signed

Version 04/08/2022

Harford Gastroenterology Associates

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Beneficial Interest/Compensation Arrangement Disclosure Statement

As responsible health care practitioners, Drs. Gao, Mu, Viswanathan, Nasser, Park and Sood, strive to provide their patients with high quality medical care and service. In certain instances, your physician may conclude based on your medical condition that a surgical procedure medically warrants the use of anesthesia.

Your physician, Dr._____, has determined based on your medical condition that a surgical procedure necessitating anesthesia is medically warranted. Please note that your physician has an ownership interest in Bel Air Sedation, LLC, the company that provides anesthesia services at the Harford Endoscopy Center. This constitutes a "beneficial interest" for purposes of Maryland Health Occupation Code 1-303(b) (1).

Accordingly, you are hereby advised of three choices:

1. You are free to choose to obtain anesthesia services from a health care entity other than Bel Air Sedation, LLC. If you elect this option, your procedure will be scheduled at Upper Chesapeake Medical Center.
2. You may opt to undergo the surgical procedure at Harford Endoscopy Center without anesthesia. This may cause discomfort during the procedure and may increase the likelihood of the procedure being incomplete.
3. You may opt to undergo the surgical procedure at Harford Endoscopy Center with anesthesia provided by Bel Air Sedation, LLC.

Please acknowledge that you have received and read a copy of this disclosure form by signing and dating in the space provided below. Your physician will place the executed form in your medical record. If you have any questions about this disclosure, please direct them to your physician.

***

Acknowledgement of Receipt of Disclosure Statement

I hereby acknowledge that I have received and reviewed the Beneficial Interest/ Compensation Arrangement Disclosure Statement and I hereby authorize my physician to proceed with my medical care, including the procedure requiring anesthesia.

_____ _____

Signature of Patient/Parent/Guardian Date

Version 4/8/2022 Replaces form HARGAS24

Harford Gastroenterology Associates

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you gain access to this information. Please review it carefully.

Protected health information (PHI) about you is maintained as a written and/or electronic record of your visits and/or contacts for healthcare services with our practice. Specifically, PHI is information about you, including demographic information that may identify you and relates to your past, present, or future physical or mental condition and related healthcare services, including payment, billing, and insurance information.

What follows is a statement of your rights under the privacy rule with regard to your PHI. Please feel free to discuss any questions surrounding this with our office staff.

Our Legal Duty. Harford Gastroenterology Associates is required by law to protect and maintain the privacy of your PHI, to provide this notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect.

You have the right to receive, and we are required to provide you with a copy of this Notice of Privacy Practices. We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices. The notice will also be posted in a conspicuous location within the practice.

You have the right to inspect and copy your PHI. This means you may inspect, and obtain a copy of your healthcare record. If your record is maintained electronically, you have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You may have the right to request an amendment to your protected health information. You may request an amendment of your PHI for as long as we maintain this information. In certain cases, however, your request may be denied.

You have the right to request disclosure accountability. This means that you may request a listing of disclosures that we have made of your PHI to entitled or persons outside of our office.

You have the right to request a restriction of you PHI. You may ask us in writing, to restrict how your PHI is used and/disclosed to carry out treatment, payment, or health operations. We are not required to agree to such restrictions, but once such restrictions are agreed to, we must adhere to such restrictions.

Chesapeake Regional Information System for our Patients (CRISP). We are participating with CRISP, a regional health information exchange, serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access and assist your doctor and health care team in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drub Monitoring Program, will still be made available to our providers.

Complaints. If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact us or The US Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Office Manager at Harford Gastroenterology Associates, 100 Walter Ward Blvd., Suite 100, Abingdon, MD 21009. Phone 443-643-4700.

Harford Gastroenterology Associates

Acknowledgement of Receipt of Notice Of Privacy Practices

Patient Name: _____ DOB: _____ Account #_____

Authorization to Disclose Health Information to Family Members or designated persons:

Name	Relationship
Name	Relationship
Name	Relationship

By signing below I am acknowledging that:

- I am either the patient or the patient's person representative.
- I have received a copy of the Notice of Privacy Practices for Harford Gastroenterology Associates.
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

Signature of patient or parent/legal guardian or legally responsible person _____ Date _____

Relationship to the patient _____

Office Use Only

Complete if signature requested by not obtained:

Harford GI staff member sought but was unable to obtain an acknowledgement from the patient or the patient's personal representative for the following reason:

☐ Patient / person representative refused

☐ Other:

_____

_____

_____

Harford GI Staff Signature: _____

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Patient Account #_____

AUTHORIZATION FOR USE OF ANSWERING MACHINES AND RELEASE OF INFORMATION TO OTHERS

Harford Gastroenterology Associates, P.A. Physicians, Nurse Practitioner, and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our office may leave messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule, we must obtain your authorization to use this mode of communication. Protected health information that we may possibly disclose on your home, work or cell phone may include, but is not limited to: test results, prescription/pharmacy information, appointment instructions for visits and/or procedures, and other information deemed necessary by your healthcare provider.

Please initial the following if you DO consent to the following. Please leave blank if NO consent is given.

_____(initial) I agree to allow Harford Gastroenterology Associates. P.A. Physicians, Nurse Practitioner, and healthcare staff to leave messages that include Protected Health Information on the following communication devices.

_____home number, _____work number, _____cell number

_____(initial) I consent to having my medical and demographic information shared with other healthcare entities. **(CRISP- C**hesapeake **R**egional **I**nformation **S**ystem for our **P**atients) More information can be found on the Notice of Privacy Practices.

_____(initial) I would like to receive preventative care and follow up reminders by either mail or patient portal.

_____(initial) I consent to obtaining a history of medications purchased at pharmacies.

_____ _____

Patient's Signature Date

_____ _____

Witness Signature Date

Version 04/7/2022

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HIPAA-Compliant Authorization to Release Medical Records

Patient's Full Name _____ **Patients Date of Birth** _____

Address _____ **City, State, Zip Code** _____

Patient's Telephone _____

I hereby authorize you to release to HARFORD GASTROENTEROLOGY ASSOCIATES a copy of my medical records. These records will be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Furthermore, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, is no longer protected under privacy rules.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.

INFORMATION TO BE RELEASED FROM:

Organization/Contact Name _____

Street Address _____

City, State, Zip Code _____

Telephone Number _____

INFORMATION TO BE RELEASED TO:

Harford Gastroenterology Associates
100 Walter Ward Boulevard
Suite 100
Abingdon, MD 21009
Phone: 443-347-4700
Fax: 443-643-4707

TYPES OF RECORDS REQUESTED

- □ Date of Service: From_____ to _____
- □ Health care information related to the following treatment or condition _____
  _____
- □ Laboratory/diagnostic tests_____
  _____
- □ Other _____
  _____

Purpose or need for this information: □ Continuing Care □ Copies for Own Use □ Other

Date _____ Signature of Patient or Legally Responsible Party _____ Description of Authority to Act for the Individual _____

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100 Walter Ward Boulevard, Suite 100
Abingdon, Maryland 21009
Ph: 443.347.4700
or 443.643.4700
Fax: 443.643.4707

www.harfordgi.com

251 Lewis Lane, Suite 105
Havre de Grace, Maryland 21078
Ph: 410.939.5082
Fax: 410.939.6291

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 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: _____ **O** Covid-19 Dose 1 When: _____ **O** Covid-19 Dose 2 When: _____ **O** Covid-19 Booster 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: _____
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 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…?

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: _____