Harford Gastroenterology Associates

Oluwasayo Adeyemo, MD, MPH
Weitong Mu, MD, PhD
Eiad Nasser, MD
Peter D. Park, MD
Asheesh Sood, MD

Kathleen Bocskor, FNP
Amy Johnson, AGNP
Alicia Panko, CRNP

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 Acknowledgement Appointment Scheduling Policy
- 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 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

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Office Use only:
Account #: _____
Date Received: _____
___Scanned
___Tasked
___Scheduled Date: _____
___Entered

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 9/9/2025

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
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Ph: 410.939.5082
Fax: 410.939.6291

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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: _____

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PATIENT FINANCIAL AGREEMENT

Understanding our financial policies is an important part of your overall experience with our office and staff. 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 4.

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 may be needed for your services with HGA.
5. Pre-Authorization may 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. You are 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 at 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 $50.00

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

10/14/2025

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Patient Acknowledgement
Appointment Scheduling Policy

According to the American Cancer Society's estimates for 2024, digestive system cancers have been increasing at alarming rates. Colon cancer is now among the top three most common types of cancer.
In men, the top three types are prostate, lung, and colon/rectum***
In women, the top three types are breast, lung and colon/rectum***

With significant increases in the volume of cancer diagnoses – it is important for us to change our attendance policy, in order to serve as many patients as possible.

Effective 9/1/24, Harford Gastroenterology Associates will require a minimum of 24-hour notice when cancelling or rescheduling your appointment. A cancellation with less than 24-hour notice, significantly limits our ability to make the appointment available to another patient in need. While we understand, things change – we ask that you let us know your plans, so that we have the time to schedule another patient, accordingly. Please call us at 443-347-4700.

Our office can be reached between 8am – 5pm Monday – Friday, and after-hours voicemail is available 24 hours per day.

1. A "no show" or missed appointment may be assessed a **$50** fee
2. This fee is not billable to your insurance.
3. IF you are more than 15 mins late, your appointment may be cancelled and rescheduled. The applicable fee may be charged to the account, as we do not have time to fill the appointment after the fact.
4. As a courtesy, we send a total of 4 reminders via text message, email and voice. Please ensure your phone number is correct and that you update us when any changes occur. Missed reminder calls and messages are not the responsibility of the team, as we make every effort to remind patients of their scheduled time. We expect that you'll make every effort to let us know if you can't make the appointment.
5. Repeated missed appointments, with no communication, may result in termination of our patient/physician relationship.

If you have any questions regarding the policy, please let our staff know and we will gladly clarify any questions you may have.

I have read and understand the Appointment Scheduling Policy and acknowledge the importance of attending my appointments as scheduled. I agree to notify the office with a minimum of 24-hour notice for any appointment concerns. I also agree that these terms may be amended at any time.

X_____ Date: _____

*Based on gender assignment at birth
** American Cancer Society - www.cancer.org/acs-research-news/facts-and-figures-2024.html

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:

			*Emergency Contact	**HIPAA Approved
Name	Relationship	Telephone #	◯	◯
Name	Relationship	Telephone #	◯	◯
Name	Relationship	Telephone #	◯	◯

**Emergency contact is the first person to be contacted in a medical emergency.*
***HIPAA contact is someone who can receive information about your medical condition(s).*

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 10/10/2025

Harford Gastroenterology Associates

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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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Patient Information Form

*The following information is **very important to your health**. Please take time to completely fill out all 4 pages.*

Name_____ **DOB**_____ **Height/Weight** _____
Primary Care Doctor_____ **Cardiologist**_____
Reason for Visit_____

Race: ___ White/Caucasian ___ Black or African American ___ Asian ___ American Indian/Alaska Native

___ Native Hawaiian/Pacific Islander ___ Unknown ___Patient declines to provide information

Preferred Language: ___English ___ Korean ___ Spanish ___ Other: _____

Ethnicity: ___ Hispanic/Latino ___ Not Hispanic/Latino ___ Patient declines to provide information

Do you have any of the following allergies: ___Latex ___Penicillin ___ Eggs ___ Soy ___ Sulfa
Do you have any other drug or food allergies: ___ No ___ Yes **(Please List Name and Reaction Type)**

_____

Pharmacy Name, Location, and Zip Code: _____

Consent to obtain a history of medications purchased at Pharmacies ___ Yes ___ No

Do you take any GLP-1 medications (Mounjaro, Ozempic, Wegovy)? ___ Yes ___ No

Current Medications (Please fill out completely) ___ None

MEDICATION	DOSE (MG or MCG etc.)	FREQUENCY (HOW OFTEN, HOW MANY)

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
When: _____ When: _____ When: _____ When: _____ When: _____

___ Covid-19 Booster
When: _____

Have you had any of the following Diagnostic Studies done:

___ None
___ CT Scan of Abdomen/Pelvis, When: _____
___ Abdominal Ultrasound, When: _____
___ Camera Pill Examination, When: _____
___ Endoscopy, When: _____
___ Colonoscopy, When: _____
___ ERCP, 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 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 less than 80lbs?	___ No	___ Yes	
Weigh Greater than 350lbs?	___ No	___ Yes	
History of Severe Pulmonary Hypertension (lung disease: not high blood pressure?)	___ 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	
Are you able to walk independently?	___ 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 greater than 2 years
___ Hysterectomy

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

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
___ C-Pap Machine
___Other Lung problems:
___Emphysema
___Obstructive Sleep Apnea
___BiPap machine
(list)_____

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 By-Pass
___ C-Section
___ Other Major Surgeries (list)_____
___ Appendix Surgery
___ Hysterectomy
_____
_____

I use tobacco: ___ Yes ___ No ___Cigarettes ___Pipe ___Cigars ___Chew ___Vape(Smokeless) Packs Per Day___ No. Years__ I quit smoking___months ago ___years ago	**I drink alcohol:** ___ Yes ___ No ____per day ____per week	**Caffeine**:(coffee, tea, cola): ___Cups per day	**Recreational or street drugs in the past?** ___ Yes ___ No **Recreational or street drugs now?** ___ Yes ___ No **History of IV (intravenous) drug use?** ___ Yes ___ No **Medical Marijuana use?** ___ Yes ___ No

Have you had any of these symptoms *IN THE PAST SIX MONTHS*? (Mark those that apply)

ENMT
____ Glaucoma
____ Difficulty swallowing
____ Hoarseness
____ Mouth sores
____ Sore throat

ALLERGIC/IMMUNOLOGIC
____ HIV Exposure
____ Food Allergy

CARDIOVASCULAR
____ Murmur
____ Chest pain
____ Swelling of legs
____ Irregular heart
____ High blood pressure

CONSTITUTIONAL
____ Fatigue
____ Loss of appetite
____ Weight gain (unintentional)
____ Weight loss (unintentional)
____ Fever

ENDOCRINE
____ Diabetes
____ Hyper/hypothyroidism

GASTROINTESTINAL
____ Indigestion
____ Peptic ulcer disease
____ Hepatitis
____ Gall bladder disease
____ Pancreatitis
____ Diarrhea
____ Constipation (3 or less Bowel movements a week)
____ Rectal bleeding
____ Nausea
____ Vomiting
____ Food intolerance
____ Swallowing pain
____ Abdominal pain
____ Abdominal swelling
____ Change in bowel habits
____ Gas
____ Heartburn
____ Jaundice(yellowing of skin)

GENITOURINARY
____ Kidney Stones
____ Dark Urine
____ Hematuria

HEMATOLOGIC/LYMPHATIC
____ Anemia
____ Bleeding disorder
____ Blood Transfusion
____ Clots
____ Aneurysm

INTEGUMENTARY
____ Hives
____ Rashes
____ Itching
____ Jaundice

MUSCULOSKELETAL
____ Arthritis
____ Gout

NEUROLOGICAL
____ Seizures
____ Stroke
____ Mini-Stroke
____ Frequent Headaches
____ Migraine

PSYCHIATRIC
____ Anxiety
____ Depression
____ Hallucinations/Paranoia
____ Suicidal thoughts
____ Panic Attacks

RESPIRATORY
____ Pneumonia
____ Asthma
____ Chronic cough
____ Coughing up blood
____ Positive TB skin test or TB exposure
____ Shortness of breath

→ Family Medical History:

___ No Knowledge of family history Are you adopted? ___ No ___ Yes

Is there any family history of…?

Colon polyp	___ No	___ Yes (who?) _____	If Deceased, age_____
Colon Cancer	___ No	___ Yes (who?) _____	If Deceased, age_____
Crohn's Disease	___ No	___ Yes (who?) _____	If Deceased, age_____
GI Cancer(stomach, liver, pancreas)	___ No	___ Yes (who?) _____	If Deceased, age_____
Ulcerative Colitis	___ No	___ Yes (who?) _____	If Deceased, age_____
Liver Disease or Hepatitis	___ No	___ Yes (who?) _____	If Deceased, age_____
Celiac Sprue	___ No	___ Yes (who?) _____	If Deceased, age_____

Patient/Parent/Guardian/ Signature Date