



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



**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  
 \_\_\_\_\_

**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



## **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 10/14/2025



**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 may be 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 policies 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



**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](http://www.cancer.org/acs-research-news/facts-and-figures-2024.html)

### 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](http://www.crisphealth.org). Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug 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.





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- Chesapeake Regional Information System for our Patients)** 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



**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:**

**INFORMATION TO BE RELEASED TO:**

\_\_\_\_\_  
Organization/Contact Name

Harford Gastroenterology Associates

\_\_\_\_\_  
Street Address

100 Walter Ward Boulevard

\_\_\_\_\_  
City, State, Zip Code

Suite 100

Abingdon, MD 21009

\_\_\_\_\_  
Telephone Number

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





Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**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: (list) \_\_\_\_\_
- Emphysema
- Obstructive Sleep Apnea
- BiPap machine

**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

<p><b>I use tobacco:</b> ___ Yes ___ No</p> <p><input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe</p> <p><input type="checkbox"/> Cigars <input type="checkbox"/> Chew</p> <p><input type="checkbox"/> Vape(Smokeless)</p> <p>Packs Per Day ___ No. Years ___</p> <p>I quit smoking ___ months ago          ___ years ago</p>	<p><b>I drink alcohol:</b></p> <p>___ Yes ___ No</p> <p>___ per day</p> <p>___ per week</p>	<p><b>Caffeine:</b>(coffee, tea, cola):</p> <p>___ Cups per day</p>	<p><b>Recreational or street drugs in the past?</b> ___ Yes ___ No</p> <p><b>Recreational or street drugs now?</b> ___ Yes ___ No</p> <p><b>History of IV (intravenous) drug use?</b> ___ Yes ___ No</p> <p><b>Medical Marijuana use?</b>          ___ Yes ___ No</p>
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Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

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

<p><b><u>ENMT</u></b></p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Mouth sores</p> <p><input type="checkbox"/> Sore throat</p> <p><b><u>ALLERGIC/IMMUNOLOGIC</u></b></p> <p><input type="checkbox"/> HIV Exposure</p> <p><input type="checkbox"/> Food Allergy</p> <p><b><u>CARDIOVASCULAR</u></b></p> <p><input type="checkbox"/> Murmur</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Swelling of legs</p> <p><input type="checkbox"/> Irregular heart</p> <p><input type="checkbox"/> High blood pressure</p> <p><b><u>CONSTITUTIONAL</u></b></p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Loss of appetite</p> <p><input type="checkbox"/> Weight gain (unintentional)</p> <p><input type="checkbox"/> Weight loss (unintentional)</p> <p><input type="checkbox"/> Fever</p> <p><b><u>ENDOCRINE</u></b></p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Hyper/hypothyroidism</p>	<p><b><u>GASTROINTESTINAL</u></b></p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Peptic ulcer disease</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Gall bladder disease</p> <p><input type="checkbox"/> Pancreatitis</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation (3 or less Bowel movements a week)</p> <p><input type="checkbox"/> Rectal bleeding</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Food intolerance</p> <p><input type="checkbox"/> Swallowing pain</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Abdominal swelling</p> <p><input type="checkbox"/> Change in bowel habits</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Jaundice(yellowing of skin)</p> <p><b><u>GENITOURINARY</u></b></p> <p><input type="checkbox"/> Kidney Stones</p> <p><input type="checkbox"/> Dark Urine</p> <p><input type="checkbox"/> Hematuria</p> <p><b><u>HEMATOLOGIC/LYMPHATIC</u></b></p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Bleeding disorder</p> <p><input type="checkbox"/> Blood Transfusion</p> <p><input type="checkbox"/> Clots</p> <p><input type="checkbox"/> Aneurysm</p>	<p><b><u>INTEGUMENTARY</u></b></p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Rashes</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Jaundice</p> <p><b><u>MUSCULOSKELETAL</u></b></p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Gout</p> <p><b><u>NEUROLOGICAL</u></b></p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Mini-Stroke</p> <p><input type="checkbox"/> Frequent Headaches</p> <p><input type="checkbox"/> Migraine</p> <p><b><u>PSYCHIATRIC</u></b></p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Hallucinations/Paranoia</p> <p><input type="checkbox"/> Suicidal thoughts</p> <p><input type="checkbox"/> Panic Attacks</p> <p><b><u>RESPIRATORY</u></b></p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> Positive TB skin test or TB exposure</p> <p><input type="checkbox"/> 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  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