



The  
ENDOSCOPY  
Center, Inc.

7402 York Rd, Suite 101  
Towson, Maryland 21204  
Tel: (410) 494-0156 Fax: (410) 828-1706

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Hello:

Thank you for calling our office. We welcome you as a patient and look forward to meeting you.

Take a moment to note the date, time and office location on your appointment card. You may want to read the brochure Endoscopic Microsurgery Associates; it will help you to get to know us better.

For your convenience we have enclosed a past history inquiry for you to fill out before coming to the office. Please bring it with you on the day of your scheduled appointment. It is important for you to bring your insurance card(s) and referral (if applicable).

This time has been allocated to you; if for any reason you are not able to keep this appointment, please call us immediately at 410-494-1846. We are always happy to answer any questions, please do not hesitate to call.

Thank you again for scheduling your appointment.

Sincerely yours,

The Staff of Endoscopic Microsurgery Associates, P.A.

Mark D. Noar, M.D. & Associates



## KIOSK FORM

Please fill out form completely.  
If "None" applies, check the box.  
Bring with you on the day of your  
appointment. Thank You

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

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

## Allergies

- None     Codeine     Erythromycin     Iodine     Penicillin     Valium  
 Aspirin     Demerol     Gluten/Wheat     Morphine     Sulfa     Other \_\_\_\_\_

## PAST OR PRESENT MEDICAL PROBLEMS

- None     Colon Cancer     Heart Attack     Kidney Failure     Rheumatic Fever  
 Anal Fissure/Fistula     Colon Polyps     Heart Failure     Kidney Infection     Seizures  
 Anemia     Crohn's Disease     Heart Murmur     Kidney Stone     Sexually Transmitted Disease  
 Arthritis     Depression     Hepatitis A     Lung Cancer     Shortness of Breath  
 Asthma     Diabetes     Hepatitis B     Migraines     Skin Cancer  
 Back Pain     Diverticulitis     Hepatitis C     Milk Intolerance     Spine/Back Problems  
 Bacterial/Fungal Infection     Diverticulosis     Herpes Zoster     Mouth Ulcers     Stomach Ulcer  
 Bladder Disease     Duodenal Ulcer     Hiatal Hernia     Muscular Aches     Stroke  
 Bleeding Disorder     Easy Bruising     High Blood Pressure     Osteoporosis     TB (Tuberculosis)  
 Bleeding Gums/Nose     Eczema     High Cholesterol     Pain/Burning Throat     TB Skin Test Positive  
 Blood Cancer     Emphysema     High Triglycerides     Pancreatitis     Thyroid Disease - High  
 Bone Fracture     Esophageal Stricture     HIV/AIDS     Paralysis     Thyroid Disease - Low  
 Brain Cancer     Eye Pain     Hives     Parkinson's Disease     Urinary/Bladder Infection  
 Breast Cancer     Fatty Liver     Irregular Heartbeat     Phlebitis     Valvular Disease  
 Bronchitis     Frequent Urinary Infections     Irritable Bowel Syndrome     Pneumonia     Varices of Esophagus/Stomach  
 Chronic Lung Disease     Gall Stones     Jaundice     Prostate     Weakness/Fatigue  
 Cirrhosis of Liver     Glaucoma     Joint Pain/Swelling     Rashes     Yellow Eyes  
 Colitis     Gout     Kidney Disease     Reflux     Other \_\_\_\_\_

## SURGERIES/HOSPITALIZATION/PROCEDURES

- |  |   |   |  |   |
|--|---|---|--|---|
| <input type="checkbox"/> None                              | <input type="checkbox"/> Cholecystectomy                  | <input type="checkbox"/> Gallbladder                | <input type="checkbox"/> Liver Biopsy          | <input type="checkbox"/> Stomach        |
| <input type="checkbox"/> Anal Fissure<br>Fistula Resection | <input type="checkbox"/> Colon Resection                  | <input type="checkbox"/> Groin Hernia               | <input type="checkbox"/> Liver Resection       | <input type="checkbox"/> Thyroid        |
| <input type="checkbox"/> Appendectomy                      | <input type="checkbox"/> Colonoscopy                      | <input type="checkbox"/> Heart Valve<br>Replacement | <input type="checkbox"/> Lysis of Adhesions    | <input type="checkbox"/> Tonsillectomy  |
| <input type="checkbox"/> Back/Neck<br>Surgery              | <input type="checkbox"/> Coronary Bypass                  | <input type="checkbox"/> Hemorrhoids                | <input type="checkbox"/> Obesity Surgery       | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Breast Surgery<br>Benign          | <input type="checkbox"/> EGD                              | <input type="checkbox"/> Hiatal Hernia              | <input type="checkbox"/> Ovary                 | <input type="checkbox"/> Uterus         |
| <input type="checkbox"/> Breast Surgery<br>Cancer          | <input type="checkbox"/> ERCP                             | <input type="checkbox"/> Hysterectomy               | <input type="checkbox"/> Prostate              | <input type="checkbox"/> Other _____    |
| <input type="checkbox"/> C-Section                         | <input type="checkbox"/> Esophageal                       | <input type="checkbox"/> Joint Replacement          | <input type="checkbox"/> Small Bowel Resection |   |
| <input type="checkbox"/> Cardiac Surgery                   | <input type="checkbox"/> Esophageal Stricture<br>Dilation | <input type="checkbox"/> Kidney                     | <input type="checkbox"/> Splenectomy           |   |

## SOCIAL HISTORY MARITAL STATUS

- Single     Separated     Married  
 Divorced     Widowed

## NUMBER OF CHILDREN

- 1     2     3     4     5     6+     None

## SOCIAL HISTORY EXERCISE

- I do not exercise     I walk     I jog     I bike  
 I swim     I golf     I do aerobics     I lift weights

## SOCIAL HISTORY ALCOHOL

- Never     More than 2 days/Week  
 Rarely     Less than 2 days/Week  
 Daily     I quit using alcohol

## SOCIAL HISTORY TOBACCO

- I use tobacco products     I have never used tobacco  
 I quit using tobacco products

## SOCIAL HISTORY OCCUPATION

Occupation \_\_\_\_\_

- Veteran

## SOCIAL HISTORY HOBBIES

Patient Hobbies \_\_\_\_\_

## GASTROINTESTINAL

- |   |   |   |  |   |
|---|---|---|--|---|
| <input type="checkbox"/> None           | <input type="checkbox"/> Change bowel<br>habits | <input type="checkbox"/> Heartburn        | <input type="checkbox"/> Nausea                      | <input type="checkbox"/> Vomiting                 |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Constipation           | <input type="checkbox"/> Hemorrhoids      | <input type="checkbox"/> Pain with Bowel<br>Movement | <input type="checkbox"/> Vomiting Blood           |
| <input type="checkbox"/> Anal Pain      | <input type="checkbox"/> Dairy Intolerance      | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Rectal Bleeding             | <input type="checkbox"/> Wheat or Gluten Intolera |
| <input type="checkbox"/> Belching       | <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Jaundice         | <input type="checkbox"/> Rectal Urgency              | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Black Stools   | <input type="checkbox"/> Difficulty Swallowing  | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Reflux                      |   |
| <input type="checkbox"/> Bloating       | <input type="checkbox"/> Flatulence             | <input type="checkbox"/> Mucous in Stool  | <input type="checkbox"/> Soiling of Stools/Bowels    |   |

## REVIEW OF SYSTEMS

## URINARY

- |   |   |
|---|---|
| <input type="checkbox"/> None                         | <b>MALE</b>                                       |
| <input type="checkbox"/> Kidney Disease/Failure       | <input type="checkbox"/> Testicle Problem         |
| <input type="checkbox"/> Frequent Urinary Infections  | <input type="checkbox"/> Prostate Problems        |
| <input type="checkbox"/> Change in Urinary Frequency  |   |
| <input type="checkbox"/> Sexually Transmitted Disease | <b>FEMALE</b>                                     |
| <input type="checkbox"/> Kidney Stones                | <input type="checkbox"/> Heavy periods            |
| <input type="checkbox"/> Blood in Urine               | <input type="checkbox"/> Breast Lump              |
| <input type="checkbox"/> Sexual Difficulty            | <input type="checkbox"/> Birth Control medication |
| <input type="checkbox"/> Other _____                  |   |

## CARDIOVASCULAR

- |  |   |
|--|---|
| <input type="checkbox"/> None                    | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Ankle Swelling          | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Blueness of Extremities | <input type="checkbox"/> Palpitations         |
| <input type="checkbox"/> Chest Pain              | <input type="checkbox"/> Poor Circulation     |

## NERVOLOGICAL

- |  |  |
|--|--|
| <input type="checkbox"/> None                            | <input type="checkbox"/> Migraines               |
| <input type="checkbox"/> Changes in Vision<br>Or Hearing | <input type="checkbox"/> Numbness in Extremities |
| <input type="checkbox"/> Dizziness                       | <input type="checkbox"/> Seizure Disorder        |
| <input type="checkbox"/> Frequent Headaches              | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Limitation of Movement          | <input type="checkbox"/> Other _____             |

## CONSTITUTIONAL

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> None             | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Fever            |                                      |
| <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Other _____ |

## EYES

- |  |   |
|--|---|
| <input type="checkbox"/> None              | <input type="checkbox"/> Pain           |
| <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Visual Decline |
| <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Other _____    |

## SKIN

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> None                | <input type="checkbox"/> Hives       |
| <input type="checkbox"/> Cancer – Basal Cell | <input type="checkbox"/> Itching     |
| <input type="checkbox"/> Cancer – Melanoma   | <input type="checkbox"/> Psoriasis   |
| <input type="checkbox"/> Cancer – Squamous   | <input type="checkbox"/> Rashes      |
| <input type="checkbox"/> Dryness             | <input type="checkbox"/> Shingles    |
| <input type="checkbox"/> Easy Bruising       |                                      |
| <input type="checkbox"/> Eczema              | <input type="checkbox"/> Other _____ |

- |  |
|--|
| <input type="checkbox"/> Shortness of breath when lying flat |
| <input type="checkbox"/> Shortness of breath when exercising |
| <input type="checkbox"/> Stent of Artery                     |
| <input type="checkbox"/> Valve Disease or Surgery            |
| <input type="checkbox"/> Other _____                         |

## ENDOCRINE

- |   |   |
|---|---|
| <input type="checkbox"/> None             | <input type="checkbox"/> High Cholesterol   |
| <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> High Triglycerides |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Thyroid Disorder   |
| <input type="checkbox"/> Other _____      |   |

## PSYCHIATRIC

- |   |   |
|---|---|
| <input type="checkbox"/> None                     | <input type="checkbox"/> Loss of interest in Enjoyable Activities |
| <input type="checkbox"/> Anxiety/Panic            | <input type="checkbox"/> Loss of Sexual Desire                    |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Suicidal Thoughts                        |
| <input type="checkbox"/> Difficulty Sleeping      | <input type="checkbox"/> None                                     |
| <input type="checkbox"/> Inability to Concentrate | <input type="checkbox"/> Other _____                              |

## HEMATOLOGIC

- |   |  |
|---|--|
| <input type="checkbox"/> None               | <input type="checkbox"/> Swollen Glands        |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Use of Blood Thinners |
| <input type="checkbox"/> Easy Bruising      |  |
| <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Other _____           |



**THE ENDOSCOPY CENTER**

**Acknowledgement**

I, \_\_\_\_\_ have reviewed all pages of this kiosk form and the information contained within is correct to the best of my knowledge.

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

