



The
ENDOSCOPY
Center, Inc.

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

Hello:

We welcome you as a patient for your scheduled endoscopic procedure and look forward to meeting you. Please take a moment to review your preparation instruction sheet(s), note the date, time and location. The enclosed procedure brochure will help you to understand your endoscopy, please call if you have any questions. Also, 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 Endoscopy Center. 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

- | | | | | | |
|----------------------------------|----------------------------------|---------------------------------------|-----------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Codeine | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Demerol | <input type="checkbox"/> Gluten/Wheat | <input type="checkbox"/> Morphine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other _____ |

PAST OR PRESENT MEDICAL PROBLEMS

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

