ADVANCE ENDOSCOPY & SPECIALIST CENTER

advanceendoscopy.com

Patient Name: _____
D.O.B (dd/m/yy): _____
Height: _____ Weight: _____
Address: _____
_____
Tel: _____
Cell: _____
E-Mail ID:

OHIP NO: _____
Family Physician: _____
Occupation: _____
Emergency Contact: _____
Emergency Contact #: _____

Appointment Date :_____

1. Why are you here today?
CHIEF COMPLAINT

☐ Abdominal Pain	☐ Fever	☐ Vertigo (Dizziness)
Stools- ☐ Blood ☐ Incontinence ☐ Mucus Discharge ☐ Pus ☐ Melena (black tarry feces)	☐ Food Intolerance ☐ Appetite loss ☐ Dysphagia (Difficulty Swallowing) ☐ Lactose Intolerant (Unable to eat dairy)	☐ Crohns ☐ Irritable Bowel Syndrome ☐ Colitis ☐ Celiac Disease ☐ Diverticula
☐ Heart Burn ☐ Acid Reflux ☐ Belching	☐ Nausea ☐ Vomiting ☐ Hematemesis (Vomiting blood)	☐ Cancer ☐ Polyps ☐ Bowel Surgery ☐ Rectal Pain
☐ Bloating	☐ Weight Change	
☐ Anemia	☐ Constipation ☐ Need for laxatives ☐ Enema Use ☐ Diarrhea	☐ Others, please explain:

2. Please record **ALL** medications

Medication Name	Daily Dose	Start Date	Date of Most Recent Dose

3. Do you have any drug, food or latex allergies? ☐ YES ☐ NO
If yes, please complete the following:

Name of Drug	Type of Reaction	Name of Food	Type of Reaction

4. Are you on COUMADIN (WARFARIN) or any blood thinners? ☐YES ☐NO

5. Have you had a prior colonoscopy or endoscopy? ☐YES ☐NO
If NO, please proceed to question #6.

If YES;
Date of Procedure: _____ Location of Procedure: _____

Results: _____

6. Please list all operations during which you received general or other type of anesthetic/sedation?
Name of Operation: _____ Year: _____
Name of Operation: _____ Year: _____
Name of Operation: _____ Year: _____

7. Have you or any member of your family had a reaction to local/general anesthetic/sedation? (not including nausea or vomiting)? ☐YES ☐NO
If yes, please provide details: _____

8. Do you consume alcohol on a daily basis? ☐YES, ☐NO
If yes, Number of years _____ How much do you consume on average in a week? _____

9. Have you ever smoked or use nicotine? ☐YES, number of years ____ ☐NO
How much average per day? _____ When did you quit? (if applicable) _____

10. Do you use recreational drugs? (I.e. marijuana, cocaine) ☐YES ☐NO
If yes, please provide details: _____

11. Do you consume caffeine (i.e. coffee, tea) on a daily basis? ☐YES, number of years____ ☐NO

12. Have you ever been diagnosed with or suspected to have any of the following by a Physician:

Condition	No	Yes (Explain and indicate year diagnosed)	Don't Know / Unsure (explain)
Communicable diseases (Hepatitis/HIV Aids)			
Heart Disease(Heart Attack, Angina, Heart Failure			
Irregular Heart Beat			
Shortness Breath			
Asthma			
Sleep Apnea			
High Blood pressure			
High Cholesterol			
Bleeding Tendency			
Cancer (Please specify)			
Epilepsy			
Depression/Emotional Stress			
Arthritis?			
Malignant Hyperthermia?			
Diabetes Mellitus		**Insulin or Pills**	
Are you Pregnant?			

13. Do you have a family history of:
Cardiovascular disease ☐YES ☐NO
Polyps ☐YES ☐NO
Cancer ☐YES ☐NO
If yes, please specify:
1-Relation:_____Cancer of the: _____at Age: _____

2-Relation:_____Cancer of the: _____at Age: _____

Patient's Name : _____
Patient's Signature: _____
and Date