Canadian Place ENDOSCOPY
LEADERS IN DIGESTIVE HEALTH SCREENING

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## PATIENT QUESTIONNAIRE

NAME: _____ SEX: ❑ Male ❑ Female
DATE OF BIRTH: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____
BEST CONTACT #: _____ ADDRESS: _____
OHIP: _____ VERSION CODE: _____ _____
OCCUPATION: _____ MARTIAL STATUS: _____

TELL US ABOUT YOUR HEALTH (Please Check)

Do you have a history of any of these conditions listed below:

| ***CONDITION*** | ***NO*** | ***YES (Please Explain)*** |
|---|---|---|
| Communicable Diseases (Hepatitis/HIV/AIDS) | | |
| Heart Disease (Heart attack, angina, bypass, heart failure, irregular heart beat) | | |
| Heart Tests (Stress tests, holter, echo, angiogram) | | |
| Diabetes (if yes, are you taking pills or insulin) | | |
| High Blood Pressure | | |
| High Cholesterol | | |
| Sleep Apnea / on CPAP | | |
| Chronic Bronchitis, Emphysema, Chronic Obstructive Pulmonary Disease | | |
| Asthma | | |
| Bleeding Disorder or taking Blood Thinners | | |
| Previous/Current Cancer (year) | | |
| Epilepsy | | |
| Depression/Anxiety | | |
| Arthritis | | |
| Malignant Hyperthermia | | |
| Pregnant | | |
| Smoker (if yes, how much a day) | | |
| Drink Alcohol (if yes, how much a day) | | |
| Marijuana/Cannabis (if yes, how much a day and what form ie. edible, smoke, vape) | | |
| **ALLERGIES** (LIST IF ANY) | | |
| **MEDICATIONS** (LIST IF ANY) | | |
| **SURGERY** (LIST IF YOU HAD ANY) | | |

| TELL US ABOUT YOUR HEALTH, continued: (Please Check) | | |
|---|---|---|
| Do you have any of the symptoms listed below? (Please Check) | | |
| ***UPPER GI SYMPTOMS*** | ***LOWER GI SYMPTOMS*** | ***OTHER (Please Explain)*** |
| ❑ Heart burn / Acid reflux<br>❑ Abdominal pain / Burning<br>❑ Indigestion / Food sticks<br>❑ Nausea<br>❑ Vomiting<br>❑ Trouble swallowing<br>❑ Vomiting of blood<br>❑ Loss of appetite<br>❑ Unexplained weight loss<br>❑ Anemia<br>❑ Family history of ulcers<br>❑ Family history of stomach cancers<br>❑ Polyps removed before<br><br>OTHER: | ❑ Positive fecal occult blood test<br>❑ Family history of colon cancer<br>❑ Blood in stool<br>❑ Rectal Bleeding<br>❑ Blood on the toilet paper<br>❑ Diarrhea<br>❑ Change in stool / narrow stool<br>❑ Abdominal pain<br>❑ Constipation<br>❑ Bloating<br>❑ Loss of appetite<br>❑ Unexplained weight loss<br>❑ Anemia<br>❑ Polyps removed before<br><br>OTHER: | |

Your Family Doctor is: _____TEL: _____

Who is accompanying you today (name): _____TEL: _____

Thank You! Kindly bring this questionnaire to your appointment.