



PATIENT'S ASSESSMENT FORM

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 : _____
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1. Why are you here today?

CHIEF COMPLAINT

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

Advance Endoscopy & Specialist Centre

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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 _____ Number of drinks per day _____

9. Do you smoke or use nicotine? YES, number of years ____ NO

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

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

If yes, please specify:

1-Relation: _____ Cancer of the: _____ at Age: _____
 2-Relation: _____ Cancer of the: _____ at Age: _____

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