GI HEALTH CENTRE

ASSESSMENT FORM (FILL OUT AND BRING WITH YOU)

Name:_____ Date of birth (dd/mm/yy)_____

Age: _____Height_____ Weight_____ Marital status_____

Occupation _____ Name of Company _____

Languages spoken _____ Email (required)_____

Do you have a history of any of the below conditions?

CONDITION	**NO**	**YES (EXPLAIN)**
Communicable Diseases (Hepatitis/HIV/AIDS)		
Heart disease (heart attack, angina, bypass, heart failure, irregular heart beat) -list any recent heart investigations		
Diabetes		Insulin or Pills
High blood pressure		
High cholesterol		
Sleep apnea/on CPAP		
Shortness of breath or COPD		
Asthma		
Bleeding disorder or are you using blood thinners currently		
Previous/current cancer		
Epilepsy		
Depression		
Arthritis		
Malignant hyperthermia		
Are you pregnant or possibly pregnant?		
Other conditions? Thyroid disease? Please list		

Please list any surgeries that you have had:

1. _____ 2. . _____

3. . _____ 4. . _____

MEDICATION history: (Please list ALL current medications)

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

ALLERGIC to any MEDICATION or LATEX: □ No □ Yes, _____

Do you smoke cigarettes? □ No □ Quit (when?)_____ □ Yes(how much)_____

How much alcohol do you drink in a week? _____

Do you or have you used recreational drugs? If yes, how many times per week? _____

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PLEASE COMPLETE THE OTHER SIDE OF THIS PAGE

Have you or any family member had a severe reaction to anesthetic in the past? ☐ No ☐ Yes

-If yes, please provide details_____

Have you ever had a previous ☐ gastroscopy ☐colonoscopy ☐No previous scopes

If yes, please list the year and the findings: _____

Any family history of: ☐Stomach Cancer ☐ Colon Cancer ☐ Colonic Polyps ☐ No history

If yes please indicate relation **and** age of diagnosis: _____

_____

Please check off the reason(s) you are presenting to GI Health Centre for an appointment

Upper GI symptoms	Lower GI symptoms	Other (please explain)
☐ heartburn/acid reflux ☐ abdominal pain/burning ☐ indigestion ☐ nausea ☐ vomiting ☐ trouble swallowing ☐ vomiting of blood ☐ loss of appetite ☐ unexplained weight loss ☐ anemia ☐ family history of stomach cancer	☐ colon cancer screening ☐ diarrhea ☐ constipation ☐ blood in stool ☐ mucus in stool ☐ blood on toilet paper only ☐ bloating ☐ lower abdominal pain ☐ previous polyps ☐ family history of colon cancer ☐ new onset anemia ☐ unexplained weight loss ☐ abnormal stool test ☐ abnormal other test ☐ known crohn's disease or ulcerative colitis ☐ diverticular disease	_____ _____ _____ _____ _____ _____

☐ By checking this box I declare that I have read and understood the Block Fee Policy for GI Health Centre.

Patient Signature_____ Date (DD/MM/YY) _____

PLEASE PRINT AND BRING COMPLETED FORM WITH YOU OR FAX IT TO 905-335-5656