GI HEALTH CENTRE

ASSESSMENT FORM

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 (An allergy to sedation)		
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.

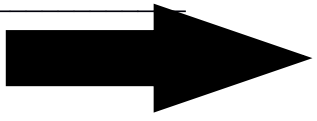
ALLERGIC to any MEDICATION or LATEX: ☐ No ☐Yes, _____

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? _____

PLEASE COMPLETE THE OTHER SIDE OF THIS PAGE



GI HEALTH CENTRE

ASSESSMENT FORM (FILL OUT AND BRING WITH YOU)

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	_____ _____ _____

Patient Signature_____ Date (DD/MM/YY) _____

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