THE TORONTO GI CLINIC

Patient Questionnaire

Name:_____ Date of Birth (yyyy-mm-dd):_____Age:_____

Height (cm):_____ Weight (kg):_____ Languages spoken:_____

What is the reason for your visit?

□ Screening Colonoscopy

□ **Abnormal Stool Appearance:**
- □ Blood
- □ Mucus
- □ Melena (Black Tarry Stool)

□ **Food Intolerance**
- □ Loss of Appetite
- □ Celiac Disease (Gluten Sensitivity)
- □ Lactose Intolerance

□ **Medical History of:**
- □ Polyps
- □ Cancer:_____
- □ Bowel Surgery: _____

□ **Change in Bowel Habits: (check both if alternating)**
- □ Constipation
- □ Diarrhea

**Please indicate number of bowel movements per day: _____

□ **Chronic Disease:**
- □ Crohn's Disease
- □ Ulcerative Colitis
- □ Irritable Bowel Syndrome

□ **Family History of:**
- □ Stomach Cancer
- □ Polyps
- □ Colon Cancer

□ **Symptoms:**
- □ Abdominal Pain
- □ Anemia
- □ Acid Reflux/Heartburn
- □ Belching
- □ Bloating
- □ Dysphagia (Difficulty Swallowing)
- □ Fever
- □ Hematemesis (Vomiting Blood)
- □ Nausea / Vomiting
- □ Unexpected Weight Loss

□ **Other (please explain):**_____

_____

_____

Have you ever been diagnosed with or been suspected to have any of the below conditions by a doctor? (If yes, please write diagnosis and the year of the diagnosis)

Are you pregnant or might be pregnant?	□ No □ Yes
Heart Disease (Heart Attack, Heart Failure, Arrhythmia, Chest Pain)	□ No □ Yes:
Shortness of Breath	□ No □ Yes:
High Blood Pressure	□ No □ Yes:
High Cholesterol	□ No □ Yes:
Diabetes Mellitus (on insulin or oral medication?)	□ No □ Yes:
Asthma / COPD	□ No □ Yes:
Sleep apnea / Using CPAP	□ No □ Yes:
Bleeding Disorder	□ No □ Yes:
Cancer	□ No □ Yes:
Epilepsy	□ No □ Yes:
Malignant Hyperthermia	□ No □ Yes:
Transmissible Disease (HIV, Viral Hepatitis, etc)	□ No □ Yes:

Have you had a gastroscopy or colonoscopy procedure in the past?

□ No □ Yes (please write the date of your last procedure, and any significant results)

Date of procedure: _____ Results: _____

Have you ever had any surgeries that required general anesthesia or sedation?

□ No □ Cholecystectomy □ Appendectomy □ Hysterectomy □ Other (please list below):

Procedure and Year	Procedure and Year	Procedure and Year

Have you or any of your relatives had a reaction to anesthesia or sedation? (both local or general)

□ No □ Yes (please explain):_____

Are you currently taking any medications daily?

□ No □ Yes (please list below):

Medication Name	Dose	Medication Name	Dose

Are you taking any blood thinners? (Coumadin/Warfarin, Plavix, Clopidogrel, Eliquis, Lovenox, etc)

□ No □ Yes (please circle from the above or write here):_____

Are you taking any pain medications? (Advil, Aleve, NSAIDs, Aspirin):

□ No □ Yes

Do you use nicotine in any form? (Smoking, vaping, gum, patches, etc):

□ No □ Yes (how many cigarettes/patches/gums per day?):_____

Do you drink alcohol?

□ No □ Yes (how many drinks per week?):_____

Do you use any recreational drugs? (Marijuana, cocaine, opioids, etc):

□ No □ Yes

Allergies: □ No known allergies □ Yes (Food, Latex, Medication, etc)

If yes, please describe: _____

_____

Date(yyyy-mm-dd):_____ Signature:_____