Southern Ontario Endoscopy Centre

HISTORY AND PHYSICAL/PRE-ANESTHETIC QUESTIONNAIRE

PLEASE BRING THIS FORM COMPLETED ON THE DAY OF THE PROCEDURE

YOU WILL NOT BE PERMITTED TO DRIVE OR WORK DAY OF PROCEDURE

REFERRING/FAMILY DOCTOR: ___________________________ PATIENT NAME: _________________________________

PATIENT DATE OF BIRTH: _________/_________/_________ HEALTH CARD #: _________________________________

Month Day Year **MUST BRING HEALTH CARD TO APPOINTMENT**

What procedure are you having today? (Please circle)

GASTROSCOPY **COLONOSCOPY**

NAME *AND* CONTACT NUMBER FOR RIDE HOME: ____

In Case of Emergency Contact (MUST BE FILLED): ____

(Name & Relation) **(Contact Number)**

PLEASE CHECK YES OR NO TO **ALL** QUESTIONS ASKED:

	YES	NO		YES	NO
Heartburn	____	____	Bloating	____	____
Difficulty swallowing	____	____	Positive H. Pylori test	____	____
Epigastric pain (stomach pain)	____	____	Lower abdominal pain	____	____
Recent change in bowel habits	____	____	Blood in stool	____	____
FIT test	____	____	Inflammatory bowel disease	____	____
Crohn's disease	____	____	Colon cancer	____	____
Ever have a lymph node resection	____	____			

Family history of colon cancer:	**YES**	**NO**	**Family history of:**	**YES**	**NO**
Father, age of diagnosis: _______	____	____	Colon polyps	____	____
Mother, age of diagnosis: _______	____	____	Colon cancer	____	____
Children, age of diagnosis: _______	____	____	Stomach cancer	____	____
Siblings, age of diagnosis: _______	____	____	Other cancer: ___________________________________		

LIST OF MEDICATIONS (include all over the counter meds and vitamins) – PLEASE DO NOT ATTACH A PRE-PRINTED LIST

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PLEASE LIST BELOW WHAT MEDICATIONS YOU TOOK TODAY:

____

DRUG ALLERGIES:

____

Have you ever been tested positive for any of the following (Please circle which ones apply):

Tuberculosis: Yes / No **Hepatitis:** Yes / No **HIV:** Yes / No **MRSA/VRE:** Yes / No