

The NEW



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Patient Questionnaire

Name: _____ DOB: _____ Contact #: _____

Age: _____ Marital status: _____ Children? _____ Occupation: _____

Have you had a previous colonoscopy? Yes No If yes, what year? _____

Have you had a previous gastroscopy? Yes No If yes, what year? _____

Past Medical History:

Heart disease	Yes	No	High blood pressure	Yes	No
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Abnormal heart rhythm	Yes	No	Liver disease	Yes	No
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Lung disease	Yes	No	Diabetes	Yes	No
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Previous stroke	Yes	No	History of cancer	Yes	No
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Other (please list): _____

Medications: Do you have any allergies to medications? Yes No

If yes, please list: _____

Please list ALL medications that you are taking. Also, include non-prescription medications such as Aspirin.

Do you currently smoke?

Yes

No

Quit _____ (when)

Do you drink alcohol?

If yes, what is the AVERAGE number of drinks consumed per week:

Number per week (on average):

1-4

5-8

9-14

15-20

21-30

>30

Family History:

Do any blood relatives have any of the following conditions:

Colon polyps

Yes

No

Stomach cancer

Yes

No

Colon cancer

Yes

No

Esophageal cancer

Yes

No

Other (please list): _____

Past Surgical History:**What Symptoms do you currently have?**

Current or recent symptoms within the last six months:

Difficulty swallowing

Yes

No

Pain on swallowing

Yes

No

Heartburn

Yes

No

Regurgitation of food

Yes

No

Bloating

Yes

No

Ulcers

Yes

No

Vomiting

Yes

No

Nausea

Yes

No

Hemorrhoids/fissures

Yes

No

Yellow eyes/skin

Yes

No

Black tarry stools

Yes

No

Blood in stool

Yes

No

Abdominal pain

Yes

No

Diarrhea

Yes

No

Constipation

Yes

No

Blood transfusion

Yes

No

How many bowel movements do you have per day on average? _____

Has this changed?

Yes

No

Any changes in your weight in the last three months?

Yes

No

If yes, amount gained _____ or lost _____

Any changes in food intake over the last year?

Yes

No

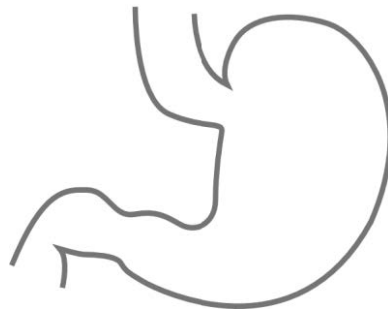
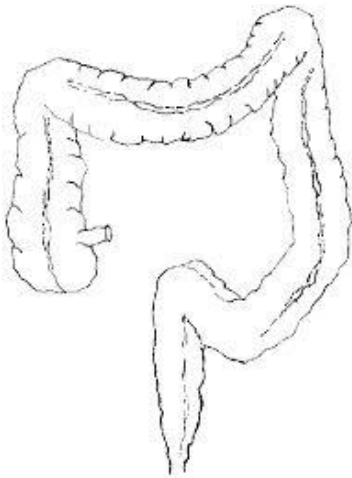
PHYSICIAN SECTION below this line

Colonoscopy/Gastroscopy:

Prep: Adequate Inadequate **BBPS** _____ **To:** Ileum Cecum

Physician Notes

Exam:



Findings: _____

Impression: _____

Recommendation: Repeat colonoscopy in _____ yrs. Other: _____

Follow-up: Endoscopist office? Family physician? **Hpylori Rx given?** Yes No

Physician: _____ **Signature** _____ **Date** _____