WestGTA Endoscopy

Patient Questionnaire

Name: _____ Birth Date:_____ Phone: _____

Age:_____ Marital status: _____Children?_____Occupation:_____

Family Physician:_____T: _____F:_____

Emergency contact:_____Relation:_____ Contact Ph:_____

Consent to Disclose Personal Health Information:

I consent to disclose my personal health information to the above listed emergency contact. _____
(Signature)

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

Medical History (Circle Yes or No):

Heart disease	Yes	No	High blood pressure	Yes	No
Abnormal heart rhythm	Yes	No	Liver disease	Yes	No
Lung disease	Yes	No	Diabetes	Yes	No
Previous stroke	Yes	No	History of cancer	Yes	No
Sleep Apnea	Yes	No	▪ if yes, type and date/age onset: _____		

Other (please list):_____

Past Surgical History:

_____

_____

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/vape? Yes No Quit ___ (when),

Marijuana? Yes No How Often_____

Do you drink alcohol? Yes No
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

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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):_____

What Symptoms do you currently have? (Circle Yes or No):

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

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CLIENT'S CONSENT

I,_____, hereby authorize Dr. _____ to perform Gastroscopy and/or Colonoscopy (using sedatives) on me. This may include polypectomy. If any unforeseen condition or situation arises during the procedure, I further authorize the same physician to do additional tests, treatments, and/or procedures that are considered necessary and ancillary to the above procedure.

- Procedure risks/complications include, but are not limited to:

☐ **Colonoscopy / Polypectomy**	☐ **Gastroscopy**
• Hemorrhage (bleeding) • Perforation (puncture) of the bowel (requiring emergency operative intervention)	• Hemorrhage (bleeding) • Aspiration • Perforation

- The above procedures are being done for either screening and/or diagnostic purposes for the prevention/diagnosis of gastro-intestinal problems.
- Additional and/or immediate investigations, treatments or operations might be recommended by the scoping physician based on his/her judgment.
- Lesions such as polyps can be missed, especially if the preparation of the gastro-intestinal tract has been less than satisfactory.
- May experience some side effects to sedation.
- I have arranged transportation upon discharge and that the clinic is not responsible for my transportation.

My questions have been answered to my satisfaction, and I have fully understood the explanations given to me. I consent to the procedure and/or treatment.

I acknowledge that…
The procedure, the risks and possible complications have been explained to me.

_____ _____
Signature of Patient / Substitute Decision-maker Date (Month/ Day/Year)

_____ _____
Signature of Interpreter Signature of Witness

Abovementioned procedure/s scheduled on this date and other information pertaining to such procedure/s have been explained to client and/or relative by the performing doctor.

_____ _____
Signature of Performing Doctor **Date (Month/Day/Year)**