HAMILTON ENDOSCOPY CENTRE

MEDICAL QUESTIONNAIRE

Please complete this brief Medical Questionnaire to the best of your ability.

Name: **Date of Birth:**

Phone #: **Gender:**

E-mail: **Occupation:**

- ***The Reason for this doctor's visit:*** _____
- ***Medications (Dose & Frequency – including herbal & over the counter medications)***

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

- ***Weight:*** _____ ***Height:*** _____ ***Allergy to Latex:*** ☐ Yes ☐ No
- ***Allergies to Medications/Food & Reaction:*** _____

_____

- ***Gastrointestinal Questions & Symptom Assessment:***

Do you experience rectal bleeding?	☐ No	☐ Yes:	Approx. date of onset:
Do you experience constipation?	☐ No	☐ Yes:	Approx. date of onset:
Do you experience diarrhea?	☐ No	☐ Yes:	Number per day: _____ Approx. date of onset:
Do you experience difficulty swallowing?	☐ No	☐ Yes:	Approx. date of onset:
Do you experience heart burn or acid reflux?	☐ No	☐ Yes:	Number per day: _____ Approx. date of onset:
Do you experience abdominal pain?	☐ No	☐ Yes:	Location: _____ Frequency:
Have you experienced unintentional weight loss?	☐ No	☐ Yes:	Amount: _____ Time frame:
Personal history of Cancer?	☐ No	☐ Yes:	Describe:
Family history of Colon Cancer?	☐ No	☐ Yes:	Relationship:
Family history of Stomach/Esophagus Cancer?	☐ No	☐ Yes:	Relationship:
Family history of Chron's Disease or Colitis?	☐ No	☐ Yes:	Relationship:
Family history of Celiac Disease?	☐ No	☐ Yes:	Relationship:

TURN OVER

Do you smoke? ☐ No ☐ Yes: Amount & Number of Years _____

Do you consume alcohol? ☐ No ☐ Yes: Amount & Frequency _____

Do you require assistance in walking? ☐ No ☐ Yes: Aid _____

➢ ***Health Check List***

Diabetes	☐ No	☐ Yes	*Lung Disease*	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes	*Asthma*	☐ No	☐ Yes
High Cholesterol	☐ No	☐ Yes	*Sleep Apnea*	☐ No	☐ Yes
Previous Heart Attack	☐ No	☐ Yes	*Hepatitis B or C*	☐ No	☐ Yes
Pacemaker	☐ No	☐ Yes	*HIV/AIDS*	☐ No	☐ Yes
Angina	☐ No	☐ Yes	*Are you Pregnant?*	☐ No	☐ Yes
Heart Valve Surgery	☐ No	☐ Yes	*Taking Blood Thinners?*	☐ No	☐ Yes
Cardiac Bypass	☐ No	☐ Yes	*Previous Blood Clots*	☐ No	☐ Yes
Kidney Disease	☐ No	☐ Yes	*TIA or Stroke*	☐ No	☐ Yes
Metal Implants	☐ No	☐ Yes	*Seizures or Epilepsy*	☐ No	☐ Yes

➢ ***Other Medical Conditions:*** _____

➢ ***Previous Surgeries***: 1. _____ 3. _____

2. _____ 4. _____

Have you ever had a problem with anesthetics or sedation? ☐ No ☐ Yes:

Explain: _____

Have you had a colonoscopy or gastroscopy in the last 5 years? ☐ No ☐ Yes:

Date: _____ Results: _____

Please list any other concerns you would like the Doctor to know about.

_____

_____

_____

Febrile Respiratory Illness Surveillance

1. Do you have a new or worse cough or shortness of breath? **YES NO**
2. Have you had a fever within the past 24 hours? **YES NO**

Multi-Resistant Organism Surveillance

1. Have you ever tested positive for Methicillin-Resistant Staphylococcus Aureus (MRSA) or Vancomycin-Resistant Enterococci (VRE)? **YES NO**
2. Have you been told that you were isolated for a specific illness such as MRSA or VRE? **YES NO**