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?

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)**