

# Patient Questionnaire

Name: \_\_\_\_\_ Date of Birth (yyyy-mm-dd): \_\_\_\_\_ Age: \_\_\_\_\_

Health Card: \_\_\_\_\_ Version Code: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_ Languages spoken: \_\_\_\_\_

## What is the reason for your visit?

- Screening Colonoscopy
  
- Abnormal Stool Appearance:**
  - Blood
  - Mucus
  - Melena (Black Tarry Stool)
  
- Food Intolerance**
  - Loss of Appetite
  - Celiac Disease (Gluten Sensitivity)
  - Lactose Intolerance
  
- Medical History of:**
  - Polyps
  - Cancer: \_\_\_\_\_
  - Bowel Surgery: \_\_\_\_\_
  
- Change in Bowel Habits: (check both if alternating)**
  - Constipation
  - Diarrhea
  - \*\*Please indicate number of bowel movements per day:**  
\_\_\_\_\_
  
- Chronic Disease:**
  - Crohn's Disease
  - Ulcerative Colitis
  - Irritable Bowel Syndrome
  
- Family History of:**
  - Stomach Cancer
  - Polyps
  - Colon Cancer
  
- Symptoms:**
  - Abdominal Pain
  - Anemia
  - Acid Reflux/Heartburn
  - Belching
  - Bloating
  - Dysphagia (Difficulty Swallowing)
  - Fever
  - Hematemesis (Vomiting Blood)
  - Nausea / Vomiting
  - Unexpected Weight Loss
  
- Other (please explain):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Have you ever been diagnosed with or been suspected to have any of the below conditions by a doctor? (If yes, please write diagnosis and the year of the diagnosis)

- |   |   |
|---|---|
| Are you pregnant or might be pregnant?                              | <input type="checkbox"/> No <input type="checkbox"/> Yes  |
| Heart Disease (Heart Attack, Heart Failure, Arrhythmia, Chest Pain) | <input type="checkbox"/> No <input type="checkbox"/> Yes: |
| Shortness of Breath   | <input type="checkbox"/> No <input type="checkbox"/> Yes: |
| High Blood Pressure   | <input type="checkbox"/> No <input type="checkbox"/> Yes: |
| High Cholesterol  | <input type="checkbox"/> No <input type="checkbox"/> Yes: |
| Diabetes Mellitus (on insulin or oral medication?)                  | <input type="checkbox"/> No <input type="checkbox"/> Yes: |
| Asthma / COPD   | <input type="checkbox"/> No <input type="checkbox"/> Yes: |
| Sleep apnea / Using CPAP  | <input type="checkbox"/> No <input type="checkbox"/> Yes: |
| Bleeding Disorder   | <input type="checkbox"/> No <input type="checkbox"/> Yes: |
| Cancer  | <input type="checkbox"/> No <input type="checkbox"/> Yes: |
| Epilepsy  | <input type="checkbox"/> No <input type="checkbox"/> Yes: |
| Malignant Hyperthermia  | <input type="checkbox"/> No <input type="checkbox"/> Yes: |
| Transmissible Disease (HIV, Viral Hepatitis, etc)                   | <input type="checkbox"/> No <input type="checkbox"/> Yes: |

**Have you had a gastroscopy or colonoscopy procedure in the past?**

- No  Yes (please write the date of your last procedure, and any significant results)

Date of procedure: \_\_\_\_\_ Results: \_\_\_\_\_

**Have you ever had any surgeries that required general anesthesia or sedation?**

- No  Cholecystectomy  Appendectomy  Hysterectomy  Other (please list below):

Procedure and Year	Procedure and Year	Procedure and Year

**Have you or any of your relatives had a reaction to anesthesia or sedation? (both local or general)**

- No  Yes (please explain): \_\_\_\_\_

**Are you currently taking any medications daily?**

- No  Yes (please list below):

Medication Name	Dose	Medication Name	Dose

**Are you taking any blood thinners? (Coumadin/Warfarin, Plavix, Clopidogrel, Eliquis, Lovenox, etc)**

- No  Yes (please circle from the above or write here): \_\_\_\_\_

**Are you taking any pain medications? (Advil, Aleve, NSAIDs, Aspirin):**

- No  Yes

**Do you use nicotine in any form? (Smoking, vaping, gum, patches, etc):**

- No  Yes (how many cigarettes/patches/gums per day?): \_\_\_\_\_

**Do you drink alcohol?**

- No  Yes (how many drinks per week?): \_\_\_\_\_

**Do you use any recreational drugs? (Marijuana, cocaine, opioids, etc):**

- No  Yes

**Allergies:**  No known allergies  Yes (Food, Latex, Medication, etc)

If yes, please describe: \_\_\_\_\_

- I understand that some physicians at this clinic use PHIPA compliant AI software for the purpose of more efficient and effective charting, and I consent to the use of this software for my healthcare appointments.

Date(yyyy-mm-dd): \_\_\_\_\_ Signature: \_\_\_\_\_