Digestive Health Clinic
Gastroenterology & Hepatology

Assessment Form

Name: _____ Date of Birth (dd/mm/yyyy):_____ Age: _____

Country of Birth:_____ If not Canada, when did you move to Canada:_____

Languages Spoken:_____Height: _____ Weight: _____

Occupation: _____ Name of Company: _____ Years employed: _____

Curently Living with (family members, independently, group home):_____

If you have children, how many? _____ If you have Grand Children, how many? _____

1. Why are you here today?

MAIN COMPLAINT

☐ SCREENING	☐ Fever	☐ Vertigo (Dizziness)
Stools: ☐ Blood ☐ Incontinence ☐ Mucus Discharge ☐ Pus ☐ Melena (black tarry feces)	☐ Food Intolerance ☐ Appetite loss ☐ Celiac Disease ☐ Lactose intolerant (Unable to eat dairy) ☐ Abdominal Pain	☐ Crohns ☐ Irritable Bowel Syndrome ☐ Colitis ☐ Diverticula ☐ Dysphagia (Difficulty Swallowing)
☐ Change in Bowel Habits ☐ Constipation How long? _____ ☐ Diarrhea How long? _____	Family History: ☐ Colon Polyps ☐ Colon cancer ☐ Stomach cancer	History of: ☐ Cancer ☐ Polyps ☐ Bowel Surgery ☐ Rectal Pain
☐ Heartburn ☐ Acid Reflux ☐ Belching ☐ Bloating ☐ Unplanned Weight Loss	☐ Nausea ☐ Vomiting ☐ Hematemesis (vomiting blood) ☐ Anemia	☐ Other, please explain in your own words: --- --- --- --- ---

PHYSICIAN NOTES:___

2. Please record ALL medications you use daily:

Medication Name	Daily Dose	Start Date	Date of Most Recent Dose	**Medication Name**	Daily Dose	Start Date	Date of Most Recent Dose

3. Do you have any drug, food, or Latex **allergies**? ☐ YES ☐ NO KNOWN ALLERGIES

If yes, please complete the following:

Name of Drug	Type of Reaction	Name of Food	Type of Reaction

4. Are you taking **any blood thinners (Coumadin, Warfarin, Plavix, Heparin, Lovenox, Aggrenox, Clopidrogel)**?

☐ YES (circle which one), Last Dose_____ ☐ NO

5. Do you use pain medications (Advil, Aleve, Tylenol, Aspirin, Etc) ☐ YES ☐ NO

6. Do you smoke or use nicotine? ☐ YES, number of years _____ ☐ NO or ☐ Quit _____years

******PLEASE COMPLETE THE REVERSE SIDE AS WELL******

7.. Alcohol consumed: # drinks:_____/Day/Week(Circle one)

8. Do you use recreational drugs? (i.e. marijuana, cocaine, etc...) □ YES □ NO
If yes, please provide details of last use: _____

9. Do you consume caffeine (i.e. coffee, tea) on a daily basis? □ YES , number of cups/day____number of years ____, □NO

10. Have you or any members of your family had a reaction to local/general anesthetic/sedation? □ YES □ NO
If Yes, please provide details: _____

11. Have you had a colonoscopy or endoscopy in the past? □ YES □ NO
If YES;
Date of Procedure: _____
Location: _____ Results: _____by Dr._____

12. Please list all **OPERATIONS** during which you received general or other type of anesthetic/sedation?
_____, Year____ _____, Year____ _____, Year____
_____, Year____ _____, Year____ _____, Year____

13. HOSPITAL VISITS; Please list any significant visits to the hospital other than surgeries listed above:
_____, Year____ _____, Year____ _____, Year____
_____, Year____ _____, Year____ _____, Year____

14. Have you ever been diagnosed with or suspected to have any of the following by a Physician:

Condition	No	Yes (explain and indicate year diagnosed)	Don't Know/Unsure
Communicable disease (Hepatitis/ HIV/Aids)			
Heart Disease(Heart Attack, Angina/chest pain, Heart Failure)			
Irregular Heart Beat			
Shortness of Breath			
Asthma			
Sleep Apnea			
High Blood Pressure			
High Cholesterol			
Bleeding Tendency			
Cancer (please specify)			
Epilepsy			
Depression/Emotional Stress			
Arthritis?			
Malignant Hyperthermia?			
Diabetes Mellitus		Insulin or Pills	
Are you Pregnant or Possibly Pregnant?			

PHYSICIAN NOTES:___

15. Family History:
Brothers (# and medical problems if any)_____
Sisters (# and medical problems if any)_____
Mother (medical problems if any)_____
Father (medical problems if any)_____

Cardiovascular/Heart disease □ YES □ NO
1- Relation_____ At age:_____ 2- Relation_____ At age:_____ 3- Relation_____ At age:_____

Cancer □ YES □ NO
If **yes**, please specify:
1- Relation:_____Cancer of : _____ at Age:____. 3- Relation:_____Cancer of : _____ at Age:____.
2- Relation:_____Cancer of : _____ at Age:____. 4- Relation:_____Cancer of : _____ at Age:____.

16. If your life is in danger due to severe blood loss, will you accept transfusion of blood, its components or products?
□ YES □ NO *****If NO, please inform the staff nurses .*****

*Signed*_____ *Date:*_____