OGI
OTTAWA GASTROINTESTINAL INSTITUTE

**PLEASE COMPLETE BOTH SIDES**

Patient's Name : _____ Date of Birth : (D/M/Y) ___ /___ / ____

Gender : □ Female □ Male Languages Spoken : _____

Reason for Appointment : _____

**Family History :**

Any members of your family diagnosed with colon/ rectal cancer ? □ Yes □ No
If **Yes** please specify : _____

Any members of your family have Colon Polyps ? □ Yes □ No
If **Yes** please specify : _____

Any members of your family diagnosed with IBD- Crohns Disease or Ulcerative Colitis ? □ Yes □ No
If **Yes** please specify : _____

**Medical History :** **HEIGHT : _____ (CM/IN), WEIGHT : _____ (KG/LBS)**

| **Diagnosis** | **Yes** | **No** | **Diagnosis** | **Yes** | **No** |
|---|---|---|---|---|---|
| High Blood Pressure | | | Asthma | | |
| Heart Disease/ Heart Attack | | | Sleep Apnea / Use CPAP Machine | | |
| Atrial Fibrillation | | | COPD/ Emphysema | | |
| Stroke / TIA | | | Hypothyrodism / Hyperthyroid | | |
| Seizures / Epilepsy | | | Glaucoma | | |
| Multiple Sclerosis (MS) | | | Crohns Disease/ Ulcerative Colitis | | |
| Diabetes | | | HIV / AIDS | | |
| Arthritis | | | Hepatitis A, B, or C (Circle) | | |
| Liver Disease – Specify _____ | | | Kidney Disease- Specify _____ | | |
| Lung Disease- Specify _____ | | | Cancer Type : _____ **Treatment :** Chemo, Radiation, Surgery (Circle) | | |

**Please List any other medical conditions if not listed above :**

_____ _____ _____

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**Current Medications :**

| **Medications** | **Yes** | **No** | **IF YES SPECIFY DOSE** |
|---|---|---|---|
| Coumadin (Warfarin), Pradaxa, Xarelto, Eliquis | | | |
| Plavix, ASA (ie. Aspirin, Aggrenox) | | | |
| NSAIDS (ie. Advil, Celebrex, Naproxen) | | | |

**Please List prescribed and over the counter medications you take regularly**

| **Medication :** | **Medication Dose :** |
|---|---|
| | |
| | |
| | |
| | |

*** ***Please attach pharmacy list to the form or write on the back of the sheet if more space is required***

**Allergies :**

Do you have allergies to Medications or Medical Products (ie. Latex, IV Contrast) ? □ Yes □ No

If **Yes** please specify : _____

**Surgical History**

CIRCLE THE ONES THAT APPLY :

| Surgical Procedure : | Year of Procedure : | Surgical Procedure | Year of Procedure : |
|---|---|---|---|
| Appendectomy (Appendix Removed) | | Pacemaker / Defibrillator | |
| Cholecystectomy (Gallbladder Removed) | | Coronary Stent/ CABG (Bypass) | |
| Colonoscopy | | Hernia Repair | |
| EGD (Upper Endoscopy) | | Tonsillectomy | |
| C-Section | | Bowel Resection | |
| Hysterectomy / Ovaries | | Hemorrhoidectomy/ Hemorrhoid Banding | |
| Tubal Ligation | | | |

**Please List any other surgical procedures if not listed above :**

_____ _____ _____

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Have you ever had Chest Pain / Angina (Chest pain related to your heart) ? □ Yes □ No

Do you experience gastric reflux, heartburn, or indigestion ? □ Yes □ No (If yes, circle which applies)

Do you use alcohol? □ Yes □ No

If **Yes** : How frequently ? _____

Are you a smoker? □ Yes □ No

If **Yes** : For how long ?_____ How many per day ?_____

Are you an ex-smoker ? □ Yes □ No
If **Yes** : When did you quit ? _____ (Month/Year)

Do you consume cannabis? □ Yes □ No

If **Yes** : For how long ? _____ How frequently ? _____

Do you use recreational drugs ? □ Yes □ No

If **Yes** please specify : _____

Do you have dentures/ caps/ crowns/ or bridges? □ Yes □ No (If yes, circle which applies)

Do you have any loose teeth? □ Yes □ No

Is there any possibility of pregnancy □ Yes □ No

Have **You** ever had any problems with Anesthesia (i.e Nausea/Vomitting, Prolonged Recovery, Reactions) ?

If **Yes** please specify : _____

Have any of your family members ever had any problems with Anesthesia (i.e. Malignant Hyperthermia) ?

If **Yes** please specify : _____

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