NORTH YORK ENDOSCOPY CENTRE

Patient Medical Information

2 CHAMPAGNE DRIVE, UNIT B19 TORONTO, ON M3J 2C5
TEL: 416-645-5145 - FAX: 416-645-1401

Name: _____ Telephone: _____

Age: _____ Occupation: _____

REASON FOR YOUR VISIT

1) Why did your doctor send you to see the Gastroenterologist?
2) Why did your doctor send you for Endoscopy?
3) When did your problem start? day_____ month_____ year_____

PREVIOUS MEDICAL ISSUES (Please check in the appropriate boxes)

4) Do you have the following diseases/problems?

High blood pressure	☐ No ☐ Yes	Stomach problems	☐ No ☐ Yes
Heart disease	☐ No ☐ Yes	Colon problems	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	Liver diseases	☐ No ☐ Yes

5) Do you take any drugs regularly? (list them) _____

_____

6) Do you take regularly
   - Aspirin ☐ No ☐ Yes
   - Pain killers ☐ No ☐ Yes
   - Blood thinners ☐ No ☐ Yes

7) Do you have any allergy to drugs? ☐ No ☐ Yes
8) Do you smoke cigarettes? ☐ No ☐ Yes Number of cigarettes per day_____
9) Do you drink alcohol? ☐ No ☐ Yes Number of drinks per week _____
10) Have you had any surgery? ☐ No ☐ Yes

11) Do you have Family History of any of the following diseases?

High blood pressure	☐ No ☐ Yes	Stomach problems	☐ No ☐ Yes
Heart disease	☐ No ☐ Yes	Colon problems	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	Liver diseases	☐ No ☐ Yes

12) Do you have any of the following symptoms?

Loss of appetite	☐ No ☐ Yes	Heartburn	☐ No ☐ Yes
Nausea or vomiting	☐ No ☐ Yes	Constipation	☐ No ☐ Yes
Pain in the abdomen	☐ No ☐ Yes	Diarrhea	☐ No ☐ Yes
Difficulty in swallowing	☐ No ☐ Yes	Blood in stool	☐ No ☐ Yes

13) How many bowel movements do you have every day? _____
14) Did you notice any change in your stool? ☐ No ☐ Yes
15) Did you notice any change in your weight? ☐ No ☐ Yes
16) Have you ever tested positive for COVID-19 or suspected you were positive for COVID-19?
☐ No ☐ Yes Date symptoms started:_____ Date symptoms ended:_____

Date: _____/_____/_____

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