Holly Endoscopy Clinic

40 Holly Street, Suite 301
Toronto, Ontario M4S 3C3

T: 416-486-8088
F: 416-486-7888

www.hollyendoscopy.ca
info@hollyendoscopy.ca

Assessment Form (FILL OUT AT HOME AND BRING WITH YOU)

Last name: First name: Sex: M / F

Date of birth: DD / MM / YYYY Age: Height: Weight: BMI:

Home address:

City: Postal code:

Email:

Telephone #: Cell #: Work #:

Health card: **Version code:**

Emergency contact: Telephone #:

Do you have a history of any of the conditions listed below?		
CONDITION	**NO**	**YES (explain)**
Communicable Diseases (Hepatitis/HIV/AIDS)		
Heart disease (heart attack, angina, bypass, heart failure, irregular heart beat) *List any recent heart investigations*		
Diabetes. Insulin or pills?		
High blood pressure		
Sleep apnea. Are you on a CPAP medicine?		
Shortness of breath or Asthma		
A bleeding disorder. Do you take blood thinners?		
Cancer. Current or previous?		
Epilepsy		
Malignant hyperthermia		
Are you pregnant or possibly pregnant?		
Other conditions? *Please list*		

Surgical History: (Please list ALL surgeries that you have had)

1: 2:

3: 4:

Medication History: (Please list ALL medications)

1: 2: 3:

4: 5: 6:

Are you allergic to any Medication? ☐ NO ☐ YES *(please list:)*

Are you allergic to any Latex? ☐ NO ☐ YES *(please list:)*

HSEC(MAR-2017 p1) Assessment Form

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Do you smoke cigarettes? ☐ No ☐ Quit *(when?)* MM / YYYY ☐ Yes *(how much)*

How much alcohol do you drink in a week?

Do you or have you used recreational drugs? ☐ No ☐ Yes *If yes, how many times per week?*

Have you or any family member had a severe reaction to anesthetic in the past? ☐ No ☐ Yes *(If yes, please provide details)*

Have you ever had a: ☐ gastroscopy ☐ colonoscopy *(If yes, please list the year and the findings:)*

Any family history of: ☐ Stomach Cancer ☐ Colon Cancer ☐ Colonic Polyps

(If yes, please indicate your relationship to the family member and their age when diagnosed:)

Please check off the reason(s) for your appointment with us:

Upper GI symptoms	Lower GI symptoms	Other (please explain)
☐ heartburn/acid reflux	☐ colon cancer screening	
☐ abdominal pain/burning	☐ diarrhea	
☐ indigestion	☐ constipation	
☐ nausea	☐ blood in stool	
☐ vomiting	☐ mucus in stool	
☐ trouble swallowing	☐ blood on toilet paper only	
☐ vomiting of blood	☐ bloating	
☐ loss of appetite	☐ lower abdominal pain	
☐ unexplained weight loss	☐ previous polyps	
☐ anemia	☐ family history of colon cancer	
☐ family history of stomach cancer	☐ new onset anemia	
	☐ unexplained weight loss	
	☐ abnormal stool test	
	☐ abnormal other test	
	☐ known Crohn's disease or ulcerative colitis	
	☐ diverticular disease	

Patient Signature: Date: DD / MM / YYYY

Please **print**, **fill out**, **sign** and **bring** this completed form with you *or* **fax** (both sides) to 416-486-7888

HSEC(MAR-2017 p2) Assessment Form