

**MARKHAM ENDOSCOPY DIAGNOSTICS INC.**

**NEW PATIENT FORM**

Please complete **BOTH SIDES** and SIGN YOUR NAME

Mr. /Ms. \_\_\_\_\_  
Mrs./ Miss \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

OHIP Number: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Which Doctor referred you to this clinic \_\_\_\_\_

Who is your Family Doctor \_\_\_\_\_

Which other Doctors have you seen \_\_\_\_\_

Have you taken the preparation for colonoscopy procedure \_\_\_\_\_

If your appointment includes a gastroscopy, did you eat or drink anything since midnight last night \_\_\_\_\_

**COMPLAINTS**

**BLEEDING**

What Colour -bright red -dark red  
Where -on the paper only -in the toilet -on the stool  
How Often -daily -weekly -monthly  
How long have you had this \_\_\_\_\_

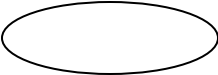
**ANAL DISCOMFORT**

Type of Pain -burning -itching -tearing  
Where -on skin -up inside  
How long have you had this \_\_\_\_\_

**SWELLING OR PROTRUSION IN THE ANAL AREA**

Painful Yes/No  
How long does the swelling last -goes right back in -stays out one hour/few days  
Where is the swelling MARK (X)  
Left < Your Front > Right  
Your Back

**ABDOMINAL PAIN**

Type of Pain -ache -bloating -cramps  
How long does the pain last \_\_\_\_\_  
How severe -mild -moderate -severe  
Where is the pain MARK (X)  
Right  Left

Does anything make it better \_\_\_\_\_  
Does anything make it worse \_\_\_\_\_  
Do you suffer from heartburn Yes/No  
Have you vomited blood or something that looks like coffee grounds Yes/No

**BOWEL HABITS**

Frequency \_\_\_\_\_ Times per day \_\_\_\_\_ Times per week \_\_\_\_\_  
Consistency -normal -hard -loose -variable  
Do you strain at stool Yes/No  
Do you take laxatives Yes/No Brand Name \_\_\_\_\_ How Often \_\_\_\_\_

**Please Turn Over**

**ANTIBIOTICS**

Do you take antibiotics before you have a dental procedure \_\_\_\_\_

**ANAL CONTROL**

Do you have "accidents" with inability to control expulsion of:

-watery stool

-soft stool

-solid stool

**HAVE YOU HAD**

|                                    |        |                |       |      |       |
|------------------------------------|--------|----------------|-------|------|-------|
| Any anal operation or injury       | Yes/No | What operation | _____ | When | _____ |
| Sigmoidoscopy                      | Yes/No | When           | _____ |      |       |
| Colonoscopy                        | Yes/No | When           | _____ |      |       |
| Colon x-ray (barium enema)         | Yes/No | When           | _____ |      |       |
| Stomach x-ray (barium meal)        | Yes/No | When           | _____ |      |       |
| Any stomach or esophagus operation | Yes/No | What operation | _____ | When | _____ |

**WHAT MEDICATIONS DO YOU TAKE REGULARLY**

\_\_\_\_\_  
\_\_\_\_\_

**DO YOU HAVE ANY OTHER HEALTH PROBLEMS**

\_\_\_\_\_  
\_\_\_\_\_

**HAVE YOU HAD ANY SERIOUS OPERATIONS OR ILLNESS**

|            |       |      |       |
|------------|-------|------|-------|
| Operation: | _____ | When | _____ |
| Operation: | _____ | When | _____ |

**DRUG ALLERGIES**

\_\_\_\_\_

**POSITIVE BLOOD TESTS**

|              |              |              |      |
|--------------|--------------|--------------|------|
| -Hepatitis A | -Hepatitis B | -Hepatitis C | -HIV |
|--------------|--------------|--------------|------|

**FAMILY HISTORY**

|                 |        |                     |       |
|-----------------|--------|---------------------|-------|
| -colon cancer   | Yes/No | Which family member | _____ |
| -breast cancer  | Yes/No | Which family member | _____ |
| -ovarian cancer | Yes/No | Which family member | _____ |
| -uterine cancer | Yes/No | Which family member | _____ |

**WHAT IS YOUR OCCUPATION**

\_\_\_\_\_

THANK YOU

PLEASE SIGN HERE: \_\_\_\_\_