**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OEC Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Family Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_ **Weight:** \_\_\_\_\_\_\_\_ **Height: \_\_\_\_\_\_\_\_**

**Marital Status:** \_\_\_\_\_\_\_\_\_\_ **Children (how many?):** \_\_\_\_\_ **Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Person Driving you Home:** **Phone**: \_\_

**MEDICAL PROBLEMS: How long? All Surgeries/Hospitalizations When?**

**⧠** High Blood Pressure **\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**⧠** Heart Disease / Angina **\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**⧠** Heart valve replacement **\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**⧠** Diabetes **\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**⧠** Liver disease **\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**Other problems: \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**MEDICATIONS: ⧠** Aspirin **⧠** Anticoagulant (blood thinner) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All other medications: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES (Drugs):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Latex allergy? Circle Y or N**

**Alcohol use? Circle Y or N Average # of drinks per DAY? \_\_\_\_\_**

**Do you smoke cigarettes? Circle Y or N How many per DAY? \_\_\_\_\_**

**FAMILY HISTORY OF: Relative (which side - Mother’s or Father’s?)**

Colon cancer / polyps \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_

Endometrial / Ovarian / Breast cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_

Liver Disease (Cirrhosis, Hepatitis) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_

Inflammatory Bowel Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_

(Crohn’s Disease, Ulcerative Colitis)

Please turn over →

 **SYMPTOMS**:

**Number of bowel movements per day:\_\_\_\_\_\_\_\_\_\_\_\_**

**Has there been a change in bowel habit? Yes / No. For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Stool Consistency:**

 ⧠ Normal Consistency

 ⧠ Semi-formed Consistency

 ⧠ Watery Consistency

 ⧠ Hard Consistency

 **Rectal Bleeding: Colour:**

 ⧠ None ⧠ N/A

 ⧠ Toilet Paper ⧠ Bright Red

 ⧠ Coated on Stool ⧠ Maroon

 ⧠ In Toilet Bowl ⧠ Black

**Abdominal Pain: Circle *Yes* *or* *No* Where? (mark with X)**

**Weight loss: Circle *Yes* *or* *No* How much? \_\_\_\_\_\_\_\_**

**Any other symptoms: Circle** *Heartburn / Problems Swallowing Food or liquid / Nausea or Vomiting*

*Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Previous colonoscopy? Circle Yes or No When? \_\_\_\_\_\_\_\_\_\_\_\_ (month/year)

Previous barium enema? Circle Yes or No When? \_\_\_\_\_\_\_\_\_\_\_\_ (month/year)

Previous stool blood test? Circle Yes or No When? \_\_\_\_\_\_\_\_\_\_\_\_ (month/year)

Previous CT (Cat Scan) Colonography? Circle *Yes or No* When? *\_\_\_\_\_\_\_\_\_\_\_\_* (month/year)

(a special CT screening for bowel cancer)

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

Patient Signature Date

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

DOCTOR TO FILL IN –

Anesthesiologist, Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICAL EXAM:

Malampatti Class: 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4 \_\_\_\_

COLONOSCOPY / GASTROSCOPY:

Midazolam \_\_\_\_\_\_\_\_\_ mg

Fentanyl \_\_\_\_\_\_\_\_\_ mcg

* Diverticulosis

ASA Class: P1 \_\_\_\_ P2 \_\_\_\_ P3 \_\_\_\_ P4 \_\_\_\_ P5 \_\_\_\_ P6 \_\_\_\_

Prep quality: (R) \_\_\_\_ (M) \_\_\_\_ (RS) \_\_\_\_ Fluid \_\_\_\_ Total \_\_\_\_

 (0-4) (0-4) (0-4) (0-2) (0-14)

Presumptive follow-up interval:

* colonoscopy in \_\_\_\_\_\_\_ years
* gastroscopy in \_\_\_\_\_\_\_ years