OAKVILLE ENDOSCOPY CENTRE INC.

2125 Wyecroft Road, Unit 5
Oakville, Ontario
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Date of procedure: ________________

OEC Physician: _________________
Family Physician: _________________

Patient Information

Patient Name: _________________________
Email Address: _________________________
Health Card #: ____________________ ____ *(Example: 8888-555-222 NN)*
Name of person driving you home: __________________________

Age: _______________
Height (feet): ________
Weight (lbs): ________
Driver Phone #: __________________

Medical Problems

Please check if applicable:

- High Blood Pressure
- High Cholesterol
- Heart Disease / Angina
- Heart valve replacement
- Diabetes
- Liver disease
- Kidney disease

Other medical problems?

____
____
____
____
____
____

List ALL surgeries/ hospitalizations below: | **When?**

List ALL surgeries/ hospitalizations	When?

Medications

Are you currently taking:

- Aspirin
- Anticoagulant
- Name of blood thinner: _____________

List ALL other medications below:

DRUG ALLERGIES: ____

Latex allergy? □ **Yes** □ **No**

Social History

Marital Status: _______________
Children (how many?): ________
Occupation: _________________

Alcohol use? □ Yes □ No
Average # of drinks per week? _____

Do you smoke? □ Yes □ No
How many per day? _____

Family History

Health Condition	Relative (which side- Mother's or Father's)	Age of Diagnosis:
Colon cancer		
Colon polyps		
Liver Disease Cirrhosis Hepatitis		
Inflammatory Bowel Disease Crohn's Disease Ulcerative Colitis		

Please turn over →

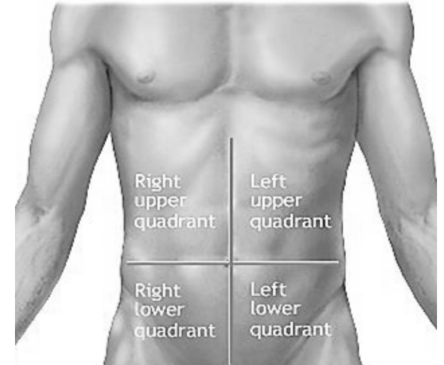
Symptoms

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:
None
Toilet Paper
Coated on Stool
In Toilet Bowl

Colour:
N/A
Bright Red
Maroon
Black



Abdominal Pain: □ Yes □ No
If yes, where? Please refer to image and check off area, if applicable →

Weight loss: □ Yes □ No
If yes, how much? _________ **Over what time frame?** ________

Any other symptoms:
Heartburn/ acid reflux
Problems swallowing food
Problems swallowing liquids
Nausea
Vomiting

Other: _______________________________________

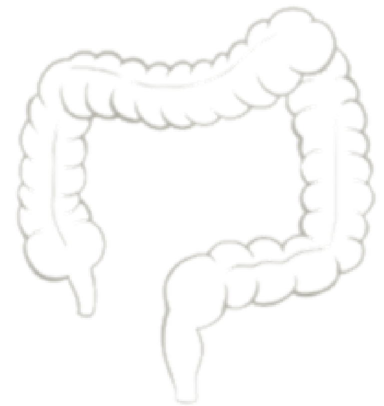
Previous colonoscopy? □ Yes □ No When? _______________________(month/year)
Previous Fecal Immunochemical Test (FIT)? □ Yes □ No When? _______________________(month/year)
Previous stool blood test? □ Yes □ No When? _______________________(month/year)

Previous CT (Cat Scan) Colonography? □ Yes □ No When? _______________________(month/year)
(a special CT screening for bowel cancer)

_______________________________ ___________________
Patient Signature *Date*

FOR OFFICE USE ONLY

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