OGI
Ottawa Gastrointestinal Institute

PATIENT DATA FORM

PATIENT NAME: _____

DATE OF BIRTH: ____/_____/_____

GENDER:_____

REASON FOR APPT_____
_____

HEIGHT:_____(CM/IN)

WEIGHT:_____(KG/LBS)

BMI: _____

Your Relevant Family History:

1. **Have any of your family members been diagnosed with colon/rectal cancer?**

   ☐ Yes
   ☐ No

   If yes, which family member?
   _____
   (Mother/Father/Sibling/Grandparent)

2. **Have any of your family members had polyps removed? Which family member?**

   ☐ Yes Specify _____
   ☐ No

3. **Have any of your family members been diagnosed with IBD (Crohn's or Ulcerative Colitis)?**

   ☐ Yes Specify _____
   ☐ No

PLEASE LIST ANY ALLERGIES YOU MAY HAVE:

☐ Medical Products (Latex, IV Contrast)
☐ Medication (please write below)

_____

_____

Do you currently take any medication that thins your blood? Check all that apply:

☐ Aspirin Other:_____
☐ Plavix (Clopidogrel)
☐ Eliquis (Apixaban)
☐ Xarelto (Rivaroxaban)
☐ Coumadin (Warfarin)
☐ Pradaxa (dabigatran)
☐ Lixiana (Edoxaban)
☐ Brillinta (Ticagrelor)

DOSE:_____

Please list all current medication and dosages:

Attach Medication List if you have it

Please Complete Page #2

Your Medical History - Please Check All That Apply:

Heart/Circulatory System

- ☐ Atrial Fibrillation
- ☐ Angina or Chest Pain
- ☐ Coronary Artery Disease
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Pacemaker/Defibrillator
- ☐ Stroke
- ☐ TIA
- ☐ Deep Vein Thrombosis
- ☐ Other_____

Lungs:

- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Pulmonary Embolism
- ☐ Other_____

Endocrine:

- ☐ Diabetes (Type 1 or 2)
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Other_____

Autoimmune Disorders:

- ☐ Celiac Disease
- ☐ Multiple Sclerosis
- ☐ Rheumatoid Arthritis
- ☐ Other_____

Infectious Disease:

- ☐ Hepatitis A, B, C (Circle)
- ☐ HIV/AIDS
- ☐ Other_____

Liver Disease:

- ☐ Fatty Liver
- ☐ Cirrhosis
- ☐ Other_____

Other:

- ☐ Sleep Apnea / Use CPAP Machine
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Kidney Disease (Specify)

  _____

- ☐ Previous Cancer Diagnosis (Type):

  _____
- ☐ Treatment (Circle) – Surgery, Radiation, Chemo
- ☐ Covid Infection (date): _____
- ☐ # of Covid Vaccinations:_____

Any Medical Conditions Not Listed Above:

_____
_____
_____
_____

Surgical History (add year if known):

- ☐ Appendectomy (Removal of Appendix)
- ☐ Cholecystectomy (Removal of Gallbladder)
- ☐ Cesarean Section (C-Section)
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Coronary Stent
- ☐ CABG (Bypass)
- ☐ Pacemaker/Defibrillator
- ☐ Hernia Repair
- ☐ Bowel Resection
- ☐ Gastroscopy (EGD)
- ☐ Hemorroidectomy
- ☐ Fistulotomy
- ☐ Tonsillectomy
- ☐ Other_____
- ☐ _____
- ☐ _____

Previous Colonoscopy Information:

Date of Last Colonoscopy:_____

Did you have polyps removed?

- ☐ Yes
- ☐ No

Lifestyle:

- ☐ Smoker
- ☐ Ex-Smoker
- ☐ Cannabis Use (Frequency)

  _____
- ☐ Alcohol Use (Frequency):

  _____
- ☐ Recreational Drug Use (Type/Frequency)

  _____

Do You Have:

- ☐ Dentures
- ☐ Caps
- ☐ Crowns
- ☐ Bridges
- ☐ Loose Teeth

Any previous issues with anesthetics? (describe)

- ☐ Yes
- ☐ No

_____

Anyone in your family have problems with anesthetics?

- ☐ Yes
- ☐ No

_____

Do you or a family member have a condition called Malignant Hyperthermia?

- ☐ Yes
- ☐ No

Specify_____

Are you:

- ☐ Pregnant
- ☐ Nursing