PLEASE SUBMIT THIS BACK PRIOR THE APPOINTMENT

Rose City Endoscopy

For Health and Peace of Mind

Operated by Dr. V. Khokhotva Medicine Professional Corporation

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Patient medical questionnaire

Today's date:_____

(Please complete **ALL** sections **and submit back prior to your appointment**)

Full name (as written on your health card):		
Date of birth (yyyy-mm-dd):		Age today:
Health card number:	Version code:	
Home address (include postal code):		
Home phone:	Work phone:	Mobile phone:
Email address:		
Emergency contact name and phone number:		
Family doctor:		

Height: _____ ft _____ in OR _____ cm	Weight: _____ lbs OR _____ kg

Do you smoke? □ Yes □ No	Do you drink alcohol? □ Yes □ No If yes, number of drinks per week:

Patient medications

(YOU must list all. DO NOT include dosage and time. DO NOT include vitamins and supplements):

Patient blood thinner medications (check all boxes that apply to you):

□ Plavix or Clopidogrel	□ Brilinta or Ticagrelor	□ Warfarin or Coumadin
□ Pradaxa or Dabigatran	□ Xarelto or Rivaroxaban	□ Eliquis or Apixaban
□ Lixiana or Edoxaban	□ Other (please write):	

Medication allergies (please write):	Latex allergy: □ Yes □ No

Previous colonoscopy: □ Yes □ No If yes, please provide date:	Were any polyps found: □ Yes □ No
Family history of colon or rectal cancer: □ Yes □ No If yes, who?	Family history of colon or rectal polyps: □ Yes □ No If yes, who?

Full name (as written on your health card):

Previous surgeries (please write):

Family history of malignant hyperthermia: □ Yes □ No

Patient medical conditions (check all boxes that apply to YOU):

□ Heart disease	□ Anxiety or depression
□ Heart attack. If yes, when?	□ Sleep apnea. If yes, do you use CPAP? □ Yes □ No
□ Pacemaker or defibrillator	□ Lung disease or trouble breathing
□ Stent in your heart. If yes, when?	□ Use of home oxygen
□ Stroke or TIA. If yes, when?	□ Walking problems. If yes, do you use: □ Wheelchair
□ Blood clots. If yes, when?	□ Walker □ Cane □ Other (please write):
□ High blood pressure	□ Parkinson's
□ Diabetes. If yes, which type? □ I □ II	□ Dementia
□ Peripheral vascular disease	□ MS
□ Liver disease	□ Alzheimer's
□ Hepatitis B or C	□ MRSA
□ Kidney disease	□ VRE
□ Aneurysm	□ HIV
□ Problems with anaesthesia. If yes, please explain.	
□ Other medical conditions (please write):	

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