Dr. Mykola Khokhotva

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Patient Questionnaire

Completed on:
(day/month/year)

Please complete **ALL** sections:

First Name:	**Last Name:**	
Date of birth (day/month/year):		Age today:
Health card number:		Version code:
Home address (include postal code):		
Home phone:	Cell phone:	Work Phone:
Emergency contact name:	Relationship to patient:	
Permission to release your health information to your emergency contact person? ◯YES ◯NO		
Emergency contact phone number:		
Family Doctor: Dr.		

Height: _____ ft and _____ 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: _____

MEDICATIONS (YOU must list your medications here - no dosage needed):

1	7	13
2	8	14
3	9	15
4	10	16
5	11	17
6	12	18

Check boxes that apply

- ☐ Plavix or Clopidogrel
- ☐ Brilinta or Ticagrelor
- ☐ Warfarin or Coumadin
- ☐ Pradaxa or Dabigatran
- ☐ Xarelto or Rivaroxaban
- ☐ Eliquis or Apixaban

Do you have allergies to medications? ◯Yes ◯No If yes, list:	Do you have allergy to Latex? ◯Yes ◯No

Previous surgeries (please list):

Previous colonoscopy: ◯Yes ◯No	If Yes to colonoscopy, please provide date (MM/YYYY):	Were any polyps found? ◯Yes ◯No

Do you have any family members with history of colon or rectal cancer? ◯Yes ◯No If yes, who?	Do you have any family members who had colon or rectal polyps? ◯Yes ◯No If yes, who?

Do you have any of these medical conditions:

Heart disease?	◯Yes ◯No	Diabetes?	◯Yes ◯No
Previous heart attack?	◯Yes ◯No	Liver disease?	◯Yes ◯No
Pacemaker or Defibrillator ?	◯Yes ◯No	Peripheral Vascular disease?	◯Yes ◯No
Stent in your heart (Coronary Arteries)?	◯Yes ◯No	Hepatitis B or C?	◯Yes ◯No
Previous stroke?	◯Yes ◯No	HIV?	◯Yes ◯No
High blood pressure?	◯Yes ◯No	Kidney disease?	◯Yes ◯No
Do you use home oxygen?	◯Yes ◯No	Current anxiety or depression?	◯Yes ◯No
Sleep Apnea?	◯Yes ◯No	Family history of Malignant Hyperthermia?	◯Yes ◯No

Please list all of your other diagnosed medical conditions:

Upper Digestive Tract Symptoms:

Do you have: Weight loss? ◯Yes ◯No	Acid reflux or heartburn? ◯Yes ◯No
Nausea or vomiting? ◯Yes ◯No	If Yes, how often? ◯Daily ◯Weekly ◯Monthly
Difficulty swallowing? ◯Yes ◯No	Have you had a gastroscopy before? ◯Yes ◯No

Lower Digestive Tract Symptoms:

Do you have:	Abdominal pain or discomfort? ◯Yes ◯No
Rectal bleeding? ◯Yes ◯No	If Yes, what type of pain? ◯Sharp ◯Dull ◯Cramping
If Yes, how often? ◯Daily ◯Weekly ◯Rarely	Where in the abdomen is the pain? (check all that apply) ☐Left ☐Right ☐Upper ☐Lower ☐Central
Tarry black stools? ◯Yes ◯No	
Constipation or straining? ◯Yes ◯No	
Frequent or severe diarrhea? ◯Yes ◯No	How often do you have a bowel movement?
Mucus with bowel movements? ◯Yes ◯No	_____ Times per day _____Times per week
Anal pain? ◯Yes ◯No	