SCOPE Clinic

Patient Questionnaire

Name:	DOB: Age:
Address:	
Marital Status: Married Single Common-law Widowed Divorced	Gender: **M** **F**
Health Card No:	Occupation:
Smoking: **Y** **N**	Alcohol: **Y** _____/week **N**

Please tell us about your health:

	Y	N	Please Specify:
Do you have FREQUENT bowel function problems?			
Has your bowel function changed?			
Have you ever passed blood?			
Do you have serious tummy pain?			
Recent weight loss?			If YES, then was the weight loss voluntary? **YES** **NO**

Family History of <u>Colorectal Cancer</u> an/or **<u>Polyps</u>** (Circle answer)**:** **YES** (Fill Table below) **NO**

	Member #1	Member #2	Member #3	Member #4
Colon/Bowel Cancer				
Colonic Polyps				

Please list your <u>MEDICAL CONDITIONS</u> and past <u>SURGERIES</u>:

Please list your MEDICATIONS (Name, Dosage, Frequency):

Drug Allergies? _____

EMERGENCY CONTACT: _____ **PHONE:** _____