Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

Dr. Vivian W. Huang

445-600 University Avenue
Toronto, Ontario, Canada M5G 1X5
**T** 416-586-4800 ext 2475
**F** 416-586-4655
mountsinai.ca

LAST NAME: _____

FIRST NAME: _____

Date of birth: Day_____ Month_____ Year_____

OHIP#: _____ Vers:_____

Address: _____

City_____ Prov_____

Home phone: ( ) _____- _____

Cell phone: ( ) _____- _____

# PATIENT QUESTIONNAIRE

***(please complete while waiting for your first appointment)***

**Who referred you to the Mount Sinai Hospital Gastroenterology clinic?**

Referring Physician: _____

Physician's Address: _____

Physician's Phone #: ( ) _____- _____ Fax #: ( ) _____- _____

**What Is the primary medical problem for which you seek evaluation, Information, or treatment?**

_____

_____

**PAST HISTORY:**

***Please Indicate If you have had any of the following:***

Blood disorders:
- Anemia: _____

Heart problems:
- Heart Attack: _____
- Heart failure: _____
- Irregular beat: _____

Lung problems:
- Asthma: _____
- COPD/emphysema: _____

Liver/kidney disorders:
- Hepatitis:_____
- Kidney disease: _____

Brain/neurological:
- Stroke: _____
- Mental disease:_____

Other disorders:
- Diabetes: _____
- Cancer: _____
- Tuberculosis: _____

**What other illness have you had? (Name and approximate date)**

_____

_____

**Are you allergic to any medications?**

**Name:** **Type of reaction:**

_____ _____

_____ _____

**MEDICATION HISTORY (Current medications)**

| Name: | Dose: | Frequency: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**REVIEW OF SYSTEMS**

Do you have any of the following (CIRCLE if YES)

| | | | |
|---|---|---|---|
| **General:** | poor appetite | weight loss | weight gain |
| | easy fatigability | needing IV iron | anxiety |
| | fever or sweats | itching | depression |
| **Digestive** | heart burn | indigestion | difficulty swallowing (solids or liquids or both) |
| **Tract** | milk intolerance | nausea and vomiting | vomiting of blood |
| | diarrhea | passing blood | abdominal pain |
| | constipation | abdominal bloating | |

**SOCIAL HISTORY**

- Marital status: single common law married divorced widowed
- Employment: not working part time full time retired
- Occupation: _____
- Smoking: non smoker ex smoker: _____ current smoker: # cigs/day:_____
- Marijuana: non user ex user: _____ currently smokes _____
- Alcohol: non drinker ex drinker _____ currently drinks: # drinks/day: _____
- Other drugs: _____

**FAMILY HISTORY:**

Do any of your blood relatives have any of the following (please CIRCLE and indicate relationship)

**Cancer:** Breast _____
Colon _____
Ovary _____
Uterus _____
Prostate _____

**IBD:** Crohn's disease _____
Ulcerative colitis _____

**Other GI:** Celiac disease _____
Irritable Bowel_____
Stomach ulcer _____

**Liver:** Hepatitis _____

**Immune:** Lupus _____
Thyroid _____
Diabetes _____

**Neurological:**

Multiple sclerosis _____
Myasthenia gravis _____

**REVIEWED BY Dr. V. HUANG: _____ DATE: _____**