Sinai Health System

Division of Gastroenterology

PACE
ADVANCING PATIENT CARE BY CROHN'S AND COLITIS CANADA

Mount Sinai Hospital - 600 University Avenue, Room 437
Toronto, Ontario, M5G 1X5
Tel: 416-586-4800 Ext. 2819 Fax: 416-586-5971

Telemedicine New Patient Questionnaire

Please speak with your physician or nurse if you need assistance completing this form

Please return this form prior to your telemedicine appointment

First Name _____ Last Name _____

Gender ☐ Male ☐ Female Birth Date ____/_____/_____ Age _____

Address _____ City _____ Postal Code _____

Home Phone _____ Work Phone _____ ext _____ Cell Phone _____

Email address _____

Please indicate your preferred method of contact: ☐ home ☐ work ☐ cell ☐ email

OHIP # _____ VC _____ Do you have a private insurance plan? ☐ Yes ☐ No

Who referred you to the Mount Sinai Hospital IBD Clinic? _____

Is this your primary care provider (Family Doctor/Nurse Practitioner? ☐ Yes ☐ No

What is the primary medical concern for which you seek evaluation, information, or treatment?

_____

_____

_____

SOCIAL HISTORY

Preferred language: _____ Do you need a translator? ☐ Yes ☐ No

Education completed: ☐ grade school ☐ high school ☐ college/university

Current employment status: ☐ employed ☐ homemaker ☐ retired ☐ unemployed

Current Occupation _____ Previous Occupation_____

Living arrangements: ☐ alone ☐ with spouse or relatives ☐ with friends
☐ dormitory ☐ nursing home other:_____

SUBSTANCE USE

Do you smoke? ☐ Never ☐ In the past ☐ Currently How long?_____

If a **current smoker**, are you interested in stopping? ☐ yes ☐ no

Alcohol use? ☐ Never ☐ In the past ☐ Currently ☐ Prefer not to discuss

Type/amount/frequency _____

Drug use? ☐ Never ☐ In the past ☐ Currently ☐ Prefer not to discuss

Type/amount/frequency _____

Indicate whether you or your relatives* have been diagnosed with any of the following diseases or symptoms. *Relatives include: parents, grandparents, siblings

Illness/Disease/Symptom	Self Age Diagnosed	Relative *	Describe/Specify
Anemia	___	☐	_____
Anxiety or Panic Attacks	___	☐	_____
Arthritis - Osteoarthritis, Rheumatoid, Psoriatic (specify)	___	☐	_____
Asthma	___	☐	_____
Autoimmune condition (specify)	___	☐	_____
Cancer (specify type)	___	☐	_____
Chronic Fatigue Syndrome	___	☐	_____
COPD / Emphysema (specify)	___	☐	_____
Depression	___	☐	_____
Diabetes (Specify: Type I, II, Gestational)	___	☐	_____
Drug / Alcohol Abuse	___	☐	_____
Epilepsy, Convulsions, or Seizures (specify)	___	☐	_____
Eye Disease (specify)	___	☐	_____
Fibromyalgia	___	☐	_____
Gallbladder Disease / Gallstones (specify)	___	☐	_____
Gout	___	☐	_____
Heart Attack /Angina / Heart Disease (specify)	___	☐	_____
Headache / Migraine (specify)	___	☐	_____
Heartburn	___	☐	_____
Hepatitis	___	☐	_____
High Cholesterol	___	☐	_____
High Blood Pressure (hypertension)	___	☐	_____
Inflammatory Bowel Disease - Crohn's or Colitis (specify)	___	☐	_____
Irritable Bowel Syndrome	___	☐	_____
Kidney Disease / Kidney Stones (specify)	___	☐	_____
Liver Disease	___	☐	_____
Lung Disease (specify)	___	☐	_____
Multiple Sclerosis	___	☐	_____
Osteoporosis	___	☐	_____
Psoriasis	___	☐	_____
Psychiatric Conditions (specify)	___	☐	_____
Shingles	___	☐	_____
Short Bowel Syndrome	___	☐	_____
Stroke	___	☐	_____
Thyroid disease – hypothyroid or hyperthyroid	___	☐	_____
Tuberculosis or a Positive TB test (specify)	___	☐	_____
Ulcer - duodenal or gastric (specify)	___	☐	_____

For yourself, do you have additional health concerns not previously listed? (describe below)

_____

_____

Bowel-Related Surgery	Year or Age
Ileocolonic resection: Removal of the terminal ileum, the last part of the small intestine and first part of the colon.	_____
Hemicolectomy: Removal of one side of the colon	_____
Proctocolectomy: Removal of the colon and rectum	_____
Colectomy: Removal of the colon	_____
Strictureplasty: Widening the narrow area of the small intestine that is affected by the disease. No part of the intestine is removed.	_____
Other: _____	_____

Diagnostic Tests (most recent)	Year or Age	Diagnostic Tests (most recent)	Year or Age
Colonoscopy	_____	CT Scan	_____
Upper Endoscopy	_____	MRI	_____
Abdominal Ultrasound	_____	Chest X-ray	_____
Other:_____	_____	Other: _____	_____

CURRENTLY, are you having any of the following symptoms?				
General	☐ fever ☐ poor appetite	☐ night sweats ☐ fear of eating	☐ fatigue ☐ weight gain	☐ infection ☐ weight loss
GI	☐ heartburn ☐ nausea ☐ bloating ☐ anal discharge ☐ rectal bleeding	☐ acid reflux ☐ vomiting ☐ swollen abdomen ☐ anal pain ☐ black stool	☐ pain with swallowing ☐ diarrhea ☐ abdominal pain ☐ swelling around the anus ☐ mucous in stool	☐ milk intolerance ☐ constipation
Head	☐ eye pain	☐ eye redness	☐ mouth sores	
Skin	☐ painful rash	☐ skin ulcers	☐ jaundice (turning yellow)	☐ itching
Joints	☐ pain	☐ swelling	☐ stiffness	
Vascular	☐ swelling in ankles		**Mood** ☐ anxiety	☐ depression

a) Thinking about the **last month**, on an **<u>average day</u>,** how many bowel movements do you have? _____

b) Of these, how many are liquid stools? _____

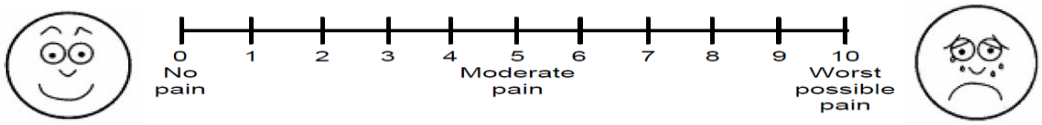
c) Do you every need to get up in the nighttime to have a bowel movement? ☐ Yes ☐ No

d) During the last **<u>2 weeks</u>**, how often has abdominal discomfort or abdominal cramping troubled you?

☐ All of the time ☐ Most of the time ☐ Some of the time

☐ Hardly any of the time ☐ None of the time

e) If you experience abdominal discomfort, please rate it using the scale below: _____ out of 10



IBD Related Medications	Current use	Previous Use	If previous use, reason stopped
Aminosalicylates			
5-Aminosalicylic acid - *5-ASA*	☐	☐	_____
Sulfasalazine	☐	☐	_____
Mesalamines - *Asacol, Pentasa, Salofalk*	☐	☐	_____
Glucocorticoids (steroids)			
Prednisone	☐	☐	_____
Hydrocortisone	☐	☐	_____
Budesonide - *Entocort*	☐	☐	_____
Steroid enema or suppository - *Cortifoam*	☐	☐	_____
Immunomodulators			
6-Mercaptopurine - *6-MP*	☐	☐	_____
Azathioprine - *Imuran*	☐	☐	_____
Methotrexate	☐	☐	_____
Cyclosporin	☐	☐	_____
Biologics			
Infliximab - *Remicade*	☐	☐	_____
Adalimumb - *Humira*	☐	☐	_____
Golimumab - *Simponi*	☐	☐	_____
Vedolizumab - *Entivo*	☐	☐	_____
Ustekinumab - *Stellara*	☐	☐	_____
Antibiotics			
Metronidazole - *Flagyl*	☐	☐	_____
Ciprofloxacin - *Cipro*	☐	☐	_____

Additional **MEDICATIONS** or attach a list of medications: pills, injectables/infusions, suppositories, enemas, over-the-counter medications (ie. Tylenol/Imodium), herbal supplements/vitamins.

Medication Name	Dose	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had a blood transfusion? ☐ yes ☐ no

Do you get an annual influenza vaccine (flu shot)? ☐ yes ☐ no

Current Weight _____ Height _____ Weight 1 year ago _____

Have you had any recent changes in your weight that you are concerned about? ☐ Yes ☐ No

We appreciate your assistance with completing this form, as it will help us better care for you.

Email completed form to **paceibd.msh@sinaihealthsystem.ca** or fax to **416-586-5971**

Print Form