Dr. N. Jedrzejko
GENERAL SURGEON | MD MSc FRCSC

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Extraordinary Caring. Every Person. Every Time.

NEW PATIENT FORM

NAME ON CARE CARD:

_____

PHONE #: _____

DATE OF BIRTH (DD/MM/YYYY):
_____/_____/_____

OHIP #: _____

OCCUPATION: _____

EMERGENCY CONTACT & PHONE #:

_____

PAST MEDICAL HISTORY (Check all that apply or have applied):

___Heart attack
___Angina
___Heart murmur
___Fast/irregular heartbeat
___High blood pressure
___Stroke
___Rheumatic fever
___Drug/alcohol abuse
___Diabetes
___Blood clotting issues
___Thyroid disease
___High cholesterol
___Hepatitis
___Anxiety/depression
___Asthma
___Lung disease
___Kidney disease
___Cancer
___Organ transplant
___Seizures
___Chronic pain
___Fibromyalgia

List any other medical diagnoses:

_____

When & where was your last colonoscopy? _____ _____Never had one

PAST SURGICAL HISTORY (Please list):

SURGERY HOSPITAL DATE

_____

_____

_____

MEDICATIONS (List all you are currently taking, including over-the-counter):

_____

_____

_____

ALLERGIES: _____

SOCIAL HISTORY

Tobacco: ___No ___Yes Year started: _____ Year quit: _____ # cig per day: ___
Alcohol: ___No ___Yes How many drinks, how often? _____
Marijuana: ___No ___Yes How much, how often? _____
Other drugs: ___No ___Yes How much, how often? _____

FAMILY HISTORY (Check all that apply):

___Colon cancer
___Rectal cancer
*Which relative*_____
*Age of diagnosis*_____
___Inflammatory bowel disease (Crohn's, ulcerative colitis)
___Breast cancer
___Other cancers
___Congenital anomalies
___Anesthetic complication