Name: _____
E-mail: _____

Dr. Sarah Miller
MD, FRCSC

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History of presenting illness:

Presenting concern: _____

_____

Duration of symptoms: _____

What makes it better? _____

What makes it worse? _____

Past medical history: Please check all that apply

- ☐ Diabetes
- ☐ Acid reflux
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ COPD/ Emphysema
- ☐ High blood pressure
- ☐ Atrial fibrillation
- ☐ Pacemaker
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Stroke
- ☐ Hypothyroidism
- ☐ Depression
- ☐ Anxiety
- ☐ Chronic pain
- ☐ Dementia
- ☐ Chronic Kidney disease
- ☐ Cancer
- ☐ Other:

Current height and weight: Height _____ Weight _____

Past surgical history: _____

_____

Medications: Please attach a list if applicable. _____

_____

Medication allergies: Please list reaction. _____

Family medical history:

- ☐ Colorectal cancer or polyps
- ☐ Crohn's/Ulcerative Colitis
- ☐ Breast cancer
- ☐ Other:

Social history:

Smoking History	Alcohol Intake	Employment Status
☐ Current smoker How much? _____ ☐ Ex-smoker. ☐ Never smoked	☐ Yes Drinks per day? _____ ☐ No	☐ Employed Position _____ ☐ Not employed ☐ Retired

Medical Records Release:

Please be aware that correspondence is often via fax. We may need to request information pertinent to your consultation. Please sign below giving us your authorization to request any required information in accordance with the Privacy Act.

Signature: _____ **Date:** _____