



The Reimer Clinic

For Health and Peace of Mind

385 Frederick Street, Unit 6
Kitchener, ON, N2H 2P2
Phone: 519-957-9730
Fax: 519-957-9732

“The Clinic” inside Walmart
1375 Baseline Road (at Clyde)
Ottawa, ON, K2C 3L9
Phone: 613-366-2021
Fax: 613-366-2025

mail@reimerclinic.ca

<http://reimerclinic.ca> / <http://cliniquereimer.ca>

Patient Information

Please complete this information to help us serve you better.

Please circle: Mr. Mrs. Miss Ms Dr. Male Female

First Name:

Last Name:

Date of Birth: Month: Day: Year: Your Age Today:

Health Card Number: Version Code: Expiry Date:

Home Address (include postal code):

Home Phone: Work Phone: Cellular Phone:

Email:

Emergency Contact Name and Phone Number:

Family Doctor: Referring Doctor (if different):

How did you hear about us?

Today's Date:



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Patient Questionnaire

Thank you for choosing The Reimer Clinic. We welcome you as our patient. Please take the time to complete this health questionnaire so that we can provide you with the best care. If you have questions, we will be happy to answer them during your visit.

NAME: _____

LARGE BOWEL QUESTIONS		
Have you had rectal bleeding? If yes: How often? (circle) DAILY WEEKLY RARELY	Yes	No
If yes: on the stool surface?	Yes	No
on the toilet paper?	Yes	No
in the toilet bowl?	Yes	No
Have you had tarry black stools? If yes: How often? (circle) DAILY WEEKLY RARELY	Yes	No
Do you have anal pain or discomfort?	Yes	No
If yes: With bowel movements?	Yes	No
after or between bowel movements?	Yes	No
Do you have frequent anal itching?	Yes	No
Do you have frequent anal mucous?	Yes	No
Do you have abdominal pain? If yes: Where? (circle) RIGHT MIDDLE LEFT UPPER MIDDLE LOWER Describe the pain: (circle) CRAMPY SHARP DULL INTERMITTENT CONTINUOUS	Yes	No
How often do you have a bowel movement? Times per day: _____ Times per week: _____		
Do you have straining or constipation?	Yes	No
Do you use laxatives? If yes: Which ones? (list)	Yes	No
Is there a change in your bowel habits lately? If yes: Explain:	Yes	No
Have you had a colonoscopy before?	Yes	No

If yes: Were any polyps found?	Yes	No
Do you have unplanned weight loss?	Yes	No
UPPER GI SYMPTOMS		
Do you have frequent nausea or vomiting?	Yes	No
Do you have difficulty swallowing food or drink?	Yes	No
Do you have heartburn or acid reflux? If yes: How often? (circle) DAILY WEEKLY RARELY	Yes	No
Do you smoke? If yes: How many per day?	Yes	No
Do you consume alcohol? If yes: How many drinks per week?	Yes	No
Do you drink coffee? If yes: How many drinks per week?	Yes	No
Do you have a history of stomach ulcers?	Yes	No
Do you have a history of <i>H. Pylori</i> infection?	Yes	No
Have you had a gastroscopy before?	Yes	No
PAST MEDICAL HISTORY		
Do you have:		
limited mobility?	Yes	No
cardiac disease, high blood pressure, prior heart attack, prior stroke?	Yes	No
vascular disease or aneurysm?	Yes	No
lung disease or trouble breathing?	Yes	No
liver or kidney disease?	Yes	No
Hepatitis B, C, HIV or AIDS?	Yes	No
diabetes?	Yes	No
problems with anesthesia?	Yes	No

PAST MEDICAL HISTORY CONTINUED...	
List any other medical history:	
PAST SURGICAL HISTORY	
List your prior surgeries:	
MEDICATIONS	
List your medications:	
ALLERGIES	
List your allergies:	

OBSTETRIC HISTORY (if applicable)		
Are you now pregnant?	Yes	No
FAMILY HISTORY		
Do you have a family history of:		
colon or rectal cancer?	Yes	No
colon or rectal polyps?	Yes	No
other cancers? If yes: Which ones? (list)	Yes	No
RISK ASSESSMENT		
What is your height?		
_____ feet and _____ inches OR		
_____ centimeters		
What is your weight?		
_____ lbs OR		
_____ kg		

Name: _____

Signature: _____

Date: _____



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Cancellation and No-Show Policy

The Reimer Clinic strives to provide fast and efficient access to endoscopic care. When an appointment is scheduled, this date and time is reserved for you. Failure to attend appointments creates delay in providing care to you and it blocks access to care for others. It also creates considerable expense to the Clinic and to the health care providers whose livelihood depends on the services provided. Therefore, the Clinic requires 24 hours notice for cancellation and/or rescheduling of appointments. In this way we can try to accommodate another client in this slot who is waiting for care.

A cancellation fee applies if you cancel your appointment with less than 24 hours notice or if you do not attend your appointment, or if you arrive late. The cancellation fee is \$400 for scheduled colonoscopies and \$200 for scheduled gastroscopies and flexible sigmoidoscopies, to a maximum of \$600. This fee will be waived if a doctors' note confirming an illness that prevents attendance is received within 96 hours of the missed appointment¹. Procedures may also be canceled in person at the time of the appointment without charge.

If an appointment is canceled or rescheduled more than twice, the client will be sent back to the family physician for referral to another practice.

I understand this policy and I agree to abide by it. In the case of cancellation fee invoices not paid after 30 days, I agree that the debt may be sent to a collection agency.

Patient Name: _____

Patient Signature: _____

Date: _____

Appointment Date and Time: _____

¹ Fees are charged under authority of Ontario Regulation 856/93, as amended (made under the *Medicine Act, 1991*), s. 1(1)20