Health Northern Sydney Local Health District	FAMILY NAME	MRN
	GIVEN NAME	☐ MALE ☐ FEMALE
Facility:	D.O.B _____/_____/_____	M.O.
	ADDRESS	
ADULT - PATIENT HEALTH QUESTIONNAIRE		
	LOCATION/WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Title: …… Family name: …… Given name: …… Middle name: ……
Sex: ☐ Male ☐ Female DOB: ……/……../……..
Medicare No: …….. Expiry date: ……..
Pension/ Centrelink number: …….. Type card ……
Do you have a private Health Insurance: ☐No ☐ Yes if Yes, type of cover: ……..
Fund name…… Fund number……
Do you choose to be a self – funded Private patient: ☐ Yes ☐ No
Country of Birth: …… Interpreter required: ☐ Yes ☐ No If YES – language: ……..
Are you of Aboriginal or Torres strait islander Origin: ☐ Yes - Aboriginal ☐ Yes – Torres Strait Islander
☐ Yes – both ☐ Neither ☐ Unknown
Emergency Contact person: …… Relationship: …… Ph: ……
Carer contact Details:

I. Carer – Is the family member or friend who regularly looks after the patient.
II. Providing care to – the patient provides care to another person
III. Carer's relationship to patient is the relationship of the carer to the patient

Do you have a Carer: ☐ Yes ☐ No
Do you consent them giving/receiving information form medical staff: ☐ Yes ☐ No
Relationship to patient …… Family name …….. Given name ……..

Address……

Home phone……Mobile……

Have you been in Hospital for any health problems including surgery? ☐No ☐Yes
If yes – What are they? When were they? (Please list)

Operation	Hospital	Year

Have you seen any other specialist doctor in the last 5 years? (if yes, please list) ☐ No ☐Yes

Reason for seeing Dr	Doctor's name	Dr Phone number	Last visit

How tall are you? …… How much do you weight? …… BMI: ……
Do you have difficulty opening your mouth wide or limited neck movement? ☐No ☐Yes
Have you had any recent anaesthetics? (Including at the dentist) ☐ No ☐ Yes
If yes when was the last one? ……
Do you have any questions, worries or concerns about the anaesthetic that you would like to talk to us about?
☐ No ☐ Yes If yes – What are they? ……

Do you have or have you ever had	**NO**	**YES**	
High blood pressure	☐	☐	If yes- When ……
Chest pain or 'angina'	☐	☐	If yes- How often……
Heart attack	☐	☐	If yes- When ……

NO WRITING

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Cardiac disease (**e.g. IHD, heart failure, pacemaker, valve disease, coronary stent, Myocardial infarction or stoke within three Months**)	☐	☐	If yes- what type……
On anticoagulant (Warfarin, Apixaban, dabigatran, rivaroxaban)	☐	☐	If yes- What type……
On antiplatelet other than aspirin (e.g. clopidogrel, prasugrel, ticagrelor, asasantin)	☐	☐	If yes- What type ……
Chronic bronchitis	☐	☐	If yes- When ……
Asthma using puffer (e.g. Ventolin)?	☐	☐	If yes- When ……
Troublesome shortness of breathe	☐	☐	If yes- When do you get it ……
Other lung or breathing problems (e.g. sleep apnoea)	☐	☐	If yes- What type……
Reflux of acid or food – heartburn/hiatus hernia	☐	☐	If yes- How often……
Diabetes	☐	☐	If yes- Do you use insulin ☐No ☐ yes Or do take diabetic tablet ☐No ☐ Yes
Epilepsy or fits	☐	☐	If yes- How often……
Stroke	☐	☐	If yes- When ……
Impaired mobility affecting independence with bowel preparation (e.g. CVA, Parkinson's)	☐	☐	If yes- What type……
Blackouts or fainting	☐	☐	If yes- When ……
Blood clots or a bleeding disorder	☐	☐	If yes- What type……
Anaemia or iron deficient?	☐	☐	If yes- When ……
Previous blood transfusion	☐	☐	If yes- When ……
Chronic kidney disease	☐	☐	If yes- What type……
Cirrhosis or advanced liver disease (e.g. Hepatitis)	☐	☐	If yes- What type……
Has your doctor prescribed for you Prednisone, cortisone or other steroids	☐	☐	If yes- When ……
Is there a condition that runs in the family E.g. thalassemia, muscle dystrophy? Advanced malignancy	☐	☐	If yes- What condition……
Do you have any other health issues	☐	☐	If yes- What ……
Previous history of difficult colonoscopy (e.g. incomplete colonoscopy, complication)	☐	☐	If yes- When ……
Have you had a specialist assessment for GI symptoms prior to colonoscopy?	☐	☐	If yes- When ……
Not mentioned above e.g. hormone therapy, poor teeth, rheumatoid arthritis? ……			
Any infectious disease ('golden staph', HIV, TB)	☐	☐	If yes- What ……
Are you pregnant?	☐	☐	
Do you smoke?	☐	☐	If yes- How much……
Do you drink alcohol?	☐	☐	If yes- How much per week……
Have you completed this questionnaire for yourself	☐	☐	If No, what is your relationship to the Patient ……

Signature of the person completing the form: …… Date: ……

NO WRITING