Sydney Gastroenterology

Name ______________________________

DOB ________ / _______/ _______

PATIENT HEALTH QUESTIONNAIRE

1. What is the main reason you have been referred to Sydney Gastroenterology?

2. Have you had any tests (for example, blood or stool tests, ultrasound or CT scans) to investigate these symptoms? If yes, please provide details and attach copies of any results (if available).

3. Have you seen a gastroenterology specialist before? If yes, please list any investigations or tests you have had and attach copies of any results (if available).

4. Have you had a gastroscopy or colonoscopy before? If yes, please provide details of when you had the procedure, who performed it for you and any results (please attach copies if available).

5. Please provide a summary of your medical history.

6. Please list any known medical conditions.

7. Please list any previous procedures.

8. Please list any medications you are currently taking or have recently been prescribed.

9. Please list any over the counter medications, vitamins or other supplements you currently use.

10. Please list any allergies.

11. Are you currently on any special diet (gluten free, lactose free, low FODMAP diet)? If yes, please provide details.

12. Do you have diabetes? If yes, please provide details.

13. Do you have a family history of gastrointestinal diseases or gastrointestinal cancer (for example, coeliac disease, Crohns disease, bowel cancer or cancer of the stomach, pancreas, oesophagus)? If yes, please list the conditions and family members affected.

14. Do you have a family history of any other medical conditions? If yes, please list the conditions and the family members affected.

15. What is your height and weight?

Height __________ cm   Weight __________ kg

16. What is your occupation?

17. Who lives at home with you?

18. Do you smoke? Please tick one option and provide the details if required.

◯ No ◯ No, but have in the past How many cigarettes per day? ______ How long did you smoke for? __________ When did you quit? __________

◯ Yes; __________ cigarettes per day

19. Do you drink alcohol? Please tick one option and provide the details if required.

◯ No ◯ No, but have in the past How many drinks per day? ______ How long did you drink for? __________ When did you quit? ______________

◯ Yes; __________ drinks per day

20. Do you smoke marijuana or use any other substances? Please provide details.

21. Other than your referring doctor, would you like a copy of your reports sent to any other treating medical professional? If so, please provide their name and address where you see them.

Patient Signature ____   Date ________ / ______ / _______