

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. Please provide the names and contact details for any other health providers involved in your care. Copies of correspondence and reports will be sent to them as well as your referring doctor.

Patient Signature _____

Date ____/____/____