WICKHAM TERRACE ANAESTHESIA

Patient Health Questionnaire

Thank you for taking the time to complete this short questionnaire. Please complete questions that are relevant to you. By providing as much detail as possible you will help your anaesthetist plan for your surgical care. If you would like to contact your anaesthetist prior to your surgery, please call our friendly staff who will assist you.

PERSONAL AND SURGERY INFORMATION

NAME: _____	D.O.B: __/__/__	WEIGHT kg: _____	HEIGHT cm: ____
ADDRESS:			
PHONE NUMBER:	EMAIL:		
OPERATION:	DATE OF SURGERY: ____/____/____	SURGEON NAME:	
OTHER SPECIALIST NAMES & ADDRESS: (e.g. Cardiologist, Endocrinologist)			
GP NAME & ADDRESS:			
DO YOU REQUIRE AN INTERPRETER? (please circle) NO YES _____			

MEDICAL HISTORY

MEDICAL SUMMARY: (please provide a short list of ongoing health problems and past surgery)	
MEDICATION LIST: (include all prescribed and non-prescribed medications, dose and time AM/PM if known)	
ALLERGIES:	
APPROXIMATE DATE OF YOUR LAST BLOOD TEST: _____	TAKEN BY: (please circle) N/A S&N QML MATER PATHOLOGY OTHER

557 Gregory Terrace, Fortitude Valley, QLD, 4006
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Patient Health Questionnaire

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (CIRCLE & PROVIDE DETAILS IF WHERE POSSIBLE)

DO YOU SMOKE?	NO	YES	How many?
HAVE YOU EVER SMOKED?	NO	YES	When did you stop?
DO YOU DRINK ALCOHOL?	NO	YES	Drinks per week
ASHTMA, BREATHING DIFFICULTIES OR RESPIRATORY DISEASE	NO	YES	Details
OBSTRUCTIVE SLEEP APNOEA	NO	YES	Do you use CPAP?
RECENT COUGH, COLD OR SORE THROAT	NO	YES	Details
HIGH BLOOD PRESSURE	NO	YES	How many years?
HISTORY OF HEART ATTACK OR ANGINA	NO	YES	Details/When
HEART STENT	NO	YES	When
ATRIAL FIBRILLATION	NO	YES	Details
HEART VALVE ABNORMALITY	NO	YES	Details
PACEMAKER OR DEFIBRILLATOR	NO	YES	Type/Last check
DIABETES	NO	YES	Type/Treatment
ACID REFLUX OR HEARTBURN	NO	YES	Treatment
HISTORY OF STROKE OR TIA	NO	YES	When
EPILEPSY	NO	YES	Explain/Details
BLOOD CLOTS IN LUNGS OR DVT IN LEGS	NO	YES	Details
BLOOD DISORDER (e.g. leukaemia, lymphoma or bleeding tendency)	NO	YES	Details
ANAEMIA	NO	YES	Details
LIVER DISEASE, HEPATITIS OR CIRRHOSIS	NO	YES	Details
KIDNEY DISEASE	NO	YES	Details/Dialysis?
ANY OTHER SERIOUS ILLNESS	NO	YES	Details
RECENTLY FINISHED CHEMOTHERAPY OR CANCER TREATMENT	NO	YES	Explain
PREGNANT OR BREASTFEEDING	NO	YES	Details
FAMILY HISTORY OF PROBLEMS WITH AN ANAESTHETIC	NO	YES	Explain

ANY FURTHER DETAILS YOU WOULD LIKE TO ADD?

_____

_____

Please include copies of any health records or results of investigations you may have e.g. ECG, echocardiography, stress test, sleep studies, spirometry.

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