PATIENT HEALTH QUESTIONNAIRE

Surname	MRN
Given Name	Male ☐ Female ☐
D.O.B: ____ / _____ / _____	M.O.
Address	
Location/ward	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	
Planned procedure:	

Name / Known as:

Patient to complete. If help is required ask your family, local doctor or phone:

Are you (is the person) of Aboriginal or Torres Strait Islander origin?

No ☐ Yes, Aboriginal ☐

Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐

Please answer the questions by ticking the applicable box/es. Add any necessary details in the space provided. Where there is not enough space, please tick the box and attach an additional information sheet.

1. Do you have any health problems other than your planned surgery? No ☐ Yes ☐
   If yes, please list: (For extra space add another sheet of paper). _____

2. Have you been in hospital for any health problems including previous surgery? No ☐ Yes ☐
   If yes, what and when were they? (Please list)

   Health problem/surgery | Hospital | Year

3. Have you seen any other specialist doctor/s in the last 5 years? If yes, please list: No ☐ Yes ☐

   Reason for seeing Dr | Dr's name | Dr's Phone Number | Last visit (date)

4. Do you use any regular medications? (e.g. pills, injections, puffers, implants, herbal, bush medicine and non-prescribed or recreational medications). If yes, please list: Attach list if more space needed. No ☐ Yes ☐

   Medication/dose: | When taken: | How often:

5. Do you have any allergies (especially to medicines, sticking plaster, iodine, food, latex). If yes, what are they and what reaction do you have? _____ No ☐ Yes ☐

6. Have you or any family member had a problem with an anaesthetic (e.g. a bad reaction). If yes, what happened?_____ No ☐ Yes ☐

7. Please indicate how far you can walk without stopping AND no chest pain or shortness of breath. Circle the one that best describes your condition. Note: A flight of stairs is considered approximately 6 steps.

More than 2 flights of stairs

2 flights stairs

1 flight of stairs

Half a flight of stairs

Around the house

Office Use Only – **PHQ TRIAGE INSTRUCTIONS**

Appendix 1 – Patient Health Questionnaire – Adult – 1/2

8. Do you have any difficult opening your mouth or have limited neck movement?	No ☐	Yes ☐
9. Have you had any recent anaesthetics? If yes when was the last one?	No ☐	Yes ☐
10. Do you have any questions, worries or concerns about the anaesthetic that you would like to talk to us about? If yes, what are they?	No ☐	Yes ☐

11. Do you have or have you ever had:

High blood pressure	No ☐	Yes ☐	When: _____
Heart attack, chest pain or 'angina'	No ☐	Yes ☐	When/How often:_____
Any other heart condition e.g. heart valve, pacemaker	No ☐	Yes ☐	What type_____
Lung problems needing hospital	No ☐	Yes ☐	What type: _____
Troublesome shortness of breath	No ☐	Yes ☐	When do you get it: _____
Chronic bronchitis	No ☐	Yes ☐	When: _____
Asthma	No ☐	Yes ☐	How often: _____
Should you be using a puffer (e.g. Ventolin)?	No ☐	Yes ☐	How often: _____
Sleep apnoea	No ☐	Yes ☐	CPAP machine (Y/N):_____
Other lung or breathing problems	No ☐	Yes ☐	What type: _____
Reflux of acid or food – heartburn / hiatus hernia	No ☐	Yes ☐	How often: _____
Diabetes	No ☐	Yes ☐	Insulin (Y/N): ___ Tablets: (Y/N) ____
Epilepsy or fits	No ☐	Yes ☐	How often: _____
Stroke	No ☐	Yes ☐	When: _____
Blackouts or fainting	No ☐	Yes ☐	When: _____
Past episodes of Delirium	No ☐	Yes ☐	Describe: _____
Dementia	No ☐	Yes ☐	Describe: _____
Intellectual disability	No ☐	Yes ☐	Describe: _____
Chronic pain	No ☐	Yes ☐	Opioids (Y/N):_____
Blood clots or a bleeding disorder	No ☐	Yes ☐	What type: _____
Anaemia	No ☐	Yes ☐	When: _____
Previous blood transfusion	No ☐	Yes ☐	When: _____
Kidney condition	No ☐	Yes ☐	What type: _____
Hepatitis or liver condition	No ☐	Yes ☐	What type: _____
Is there a condition that runs in the family e.g. thalassemia, muscular dystrophy?	No ☐	Yes ☐	What condition: _____
Do you have any other health issues not mentioned above e.g. poor teeth, rheumatoid arthritis, recent Prednisone?	No ☐	Yes ☐	List: _____
An infectious disease (e.g. 'golden staph', HIV, TB)?	No ☐	Yes ☐	List: _____
Are you pregnant?	No ☐	Yes ☐	
Do you smoke?	No ☐	Yes ☐	How much: _____
Do you drink alcohol?	No ☐	Yes ☐	How much per week: _____

Height: ☐ Weight: ☐

Form completed by: Patient ☐ Carer/relative ☐ Other ☐ Specify:

Signature of person completing form: Date:

Appendix 1 – Patient Health Questionnaire – Adult – 2/2

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