**CONFIDENTIAL PATIENT QUESTIONNAIRE**

**Personal details**

TITLE \_\_\_\_\_\_ GIVEN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PREFERRED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SURNAME:­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MALE ❒ FEMALE ❒ DATE OF BIRTH: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POSTCODE: \_\_\_\_\_\_\_\_

CONTACT NUMBERS (HOME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (WORK)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(MOBILE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NEXT OF KIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BEST CONTACT NUMBER (HOME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (WORK) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(MOBILE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICARE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EXPIRY DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT REFERENCE NUMBER (NUMBER BESIDE YOUR NAME) : \_\_\_\_\_\_\_\_\_\_\_

PRIVATE HEALTH INSURANCE: ( YES / NO )

FUND:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEMBER NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_YEAR JOINED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGED PENSIONER ( YES/NO ) PENSION NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ EXPIRY:\_\_\_\_\_\_\_\_\_\_\_\_

VETERANS AFFAIRS (YES / NO ) ( GOLD / WHITE CARD ) DVA NO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EXPIRY:\_\_\_\_\_\_\_\_\_

REGULAR GP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***CONSENT* \*\*\*\* Please read carefully as it contains important information\*\*\*\*\*\***

\* I consent to the collection, usage, disclosure and storage of my personal information in accordance with the National Privacy Principles defined under the Privacy Act 1998.

\* I understand that I will have to pay for endosQ’s Doctors services, even if I am admitted to hospital and cared for by another doctors or specialist

\* I consent to the doctors at endosQ to share information about my visit to my usual GP.

\* I consent to my GP/other doctors sharing information about me with endosQ.

\* I understand that I am responsible for tests such as X-rays, blood test and other scans.

Patient or Guardian’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical history**

Please indicate if **you have** or **have had** any of the following (circle and provide details):

|  |  |  |  |
| --- | --- | --- | --- |
| **Heart problems or Heart Surgery (chest pain, angina, heart attack, valve disease, heart murmur, irregular pulse, palpitations, stent, bypass surgery, pacemaker, defibrillator, valve replacement)** | **NO** | **YES** | please describe |
| **High blood pressure** | **NO** | **YES** | please describe |
| **Any serious illness or disabling condition eg: Osteoporosis** | **NO** | **YES** | please describe |
| **Lung problems  (shortness of breath, asthma, bronchitis, COPD, emphysema, sleep apnea, home oxygen, CPAP)** | **NO** | **YES** | please describe |
| **Diabetes** | **NO** | **YES** | ❒ insulin ❒ tablets ❒ diet-controlled |
| **Stroke, TIA, epilepsy** | **NO** | **YES** | please describe |
| **Infectious diseases  (hepatitis, jaundice, HIV, tuberculosis)** | **NO** | **YES** | please describe |
| **Blood clots in legs or lungs  (DVT, PE)** | **NO** | **YES** | please describe |
| **Kidney problems  (chronic renal failure, dialysis, stones)** | **NO** | **YES** | please describe |
| **Liver problems  (hepatitis, cirrhosis, jaundice)** | **NO** | **YES** | please describe |
| **Height: cm**  **Weight: kg** |  |  |  |

**Other medical history**

Please tell us a little more about your medical or surgical history.

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you ever had any surgery?** | **NO** | **YES** | what type of surgery? when? |
|  |  |  |  |
| **Have you or your family had any problems with anaesthetic in the past?  (drug reactions, nausea/vomiting, required intensive care)?** | **NO** | **YES** | what? |
| **Do you have any visual, hearing, mobility or other impairment?**  **(Eg: Reading Glasses, Hearing Aids)** | **NO** | **YES** |  |
| **Do you drink alcohol?**  **Do you smoke?** | **NO**  **NO** | **YES**  **YES** | how many standard drinks per week?  HOW MANY PER DAY? |
| **Do you take any blood thinning tablets or have a bleeding tendency?  (anticoagulants, antiplatelets, clotting problems)** | **NO** | **YES** | ❒ clopidogrel (Plavix/Iscover) ❒ warfarin ❒ Co-plavix  please tell us why you take this medicine? |

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you take steroid medications  (cortisone, prednisone)** | **NO** | **YES** | please describe |
| **Do you have any allergies?  (drugs, foods, tapes)** | **NO** | **YES** | please describe |

**Medications**

|  |
| --- |
| Please list all your **current medications** (and bring them on the day of your procedure).*Including Natural Therapies and over the counter medications:* |

**Gastrointestinal history**

Please answer the following specific questions about your gastrointestinal history.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Have you had an upper endoscopy or colonoscopy before?** | **NO** | **YES** | **❒ upper endoscopy ❒ colonoscopy**  **when? where?** | |
| **Do you have reflux symptoms?** | **NO** | **YES** | PLEASE DESCRIBE | |
| **Have your bowel habits changed recently?**  **Have you passed blood or mucus in your stool?**  **To help us plan your procedure, please tell us about your usual bowel habit.** | **NO YES**  **NO YES**  **❒ Normal**  **❒ Constipated**  **❒ Diarrhoea** | | | PLEASE DESCRIBE  PLEASE DESCRIBE  please describe consistency and how often |
| **Do you take any regular laxatives?** | **NO** | **YES** | what do you take? | |
| **Do you have abdominal/belly pain or tenderness?** | **NO** | **YES** | please describe | |
| **Do you or your family have any history of bowel cancer?** | **NO** | **YES** | please describe | |
| **Do you or your family have any bowel diseases? (Inflammatory Bowel Disease, Ulcerative Colitis, Crohn’s)** | **NO** | **YES** | please describe | |
| **Do you or your family have Coeliac Disease?** | **NO** | **YES** |  | |