GastroHealth Australia
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GastroHealth Australia Patient Health Questionnaire

Background Medical History

Name:				Date of birth:			
Have you ever had a history of (please tick items if yes)							
Anaemia	☐	Diabetes	☐	Depression	☐	Cancers	☐
Heart Disease	☐	Anxiety	☐	Liver Cirrhosis	☐	Kidney Disease	☐
Crohn's Disease	☐	Hepatitis	☐	Lung Disease	☐	Ulcerative Colitis	☐
Pancreatitis	☐	Reflux	☐	Coeliac Disease	☐		
Other – please specify:							
Do you smoke:				Never ☐		Former Smoker ☐	Sometimes ☐
How many packs per day?							
Do you drink alcohol				Yes ☐		No ☐	
Please indicate the quantity per week:							

Background Surgical History

Please tick any surgeries you have had and the date of the surgery			
Appendicectomy	☐	Hernia repair	☐
Cholecystectomy (Gallbladder)	☐	Hysterectomy or Prostate	☐
Bowel resection	☐	Pancreas surgery	☐
Bariatric surgery	☐	Caesarian section	☐
Other – please specify:			

Previous Endoscopy/Gastroscopy	Yes ☐	No ☐	Year(s)
Previous Colonoscopy	Yes ☐	No ☐	Year(s)

Family Medical History

Do you have a family history of the following? Please tick relevant items and specify which family member or relation to you.			
Bowel Cancer	☐	Crohn's Disease	☐
Stomach Cancer	☐	Ulcerative Colitis	☐
Pancreatic Cancer	☐	Coeliac Disease	☐
Breast Cancer	☐	Ovarian Cancer	☐
Other Cancers?			

Current Medication

Do you take any herbal medications?	Yes ☐	No ☐
If yes, please specify:		
Do you take any over the counter medications regularly?	Yes ☐	No ☐
If yes, please specify:		
Do you have any drug allergies	Yes ☐	No ☐
If yes, please specify:		

Please list any prescription drugs that you currently taking or over the past 6 months

Drugs	Dosage amount	Reason for taking