Peel Surgical Clinic – Patient Health Questionnaire

Please complete and email this form with your referral from your GP to: reception@drss.com.au

This information helps us ensure your care and sedation are safe and appropriate.

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1. Patient Details

Name: _____

Date of Birth: _____

Phone: _____

Address: _____

Medicare Number: _____

Health Fund: _____ **Membership number:** _____

Email:

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2. Past Medical History

Please tick any that apply or provide details below.

☐ High blood pressure
☐ Low blood pressure
☐ Heart disease (e.g. stents, pacemaker, defibrillator)
☐ Diabetes – ☐ Insulin dependent ☐ Non-insulin dependent
☐ Kidney disease
☐ Liver disease
☐ Asthma or lung disease
☐ Obstructive sleep apnoea – ☐ CPAP used
☐ Bleeding or clotting disorder
☐ Stroke or TIA
☐ Epilepsy or seizures
☐ Cancer (type: _____)
☐ Other: _____

Any other significant medical conditions:

_____

_____

Height (cm):_____ Weight (kg):_____ BMI (leave if unsure):_____

Have you ever had a previous Colonoscopy ☐ or Gastroscopy? ☐
If yes, please list Year: Hospital:

3. Symptoms/Indications for Endoscopy procedure

Please tick any that apply to you or provide details below.

□ Abdominal pain □ Upper □ Lower

□ Rectal bleeding/Blood on wiping

□ Previous Barrett's Oesophagus

□ Diarrhoea Duration …… (months)

□ Positive FOBT (Faecal Occult Blood Test)

□ Diverticulitis follow-up

□ Anaemia

□ Unexplained iron deficiency

□ Abnormal imaging (Ultrasound, CT, MRI etc.)

□ Change in bowel habits

□ High risk Family history (provide further info) _____

□ Surveillance - previous Polyps

□ Other – Please specify:

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4. Medications

Please list **all medications** currently taken, including prescription, over-the-counter, and supplements. You may also attach a list from your GP.

Medication Name	**Dose**	**Frequency**	**Reason (if known)**

Blood-thinning or diabetic medications:

☐ Aspirin ☐ Clopidogrel (Plavix) ☐ Warfarin ☐ Eliquis ☐ Xarelto ☐ Pradaxa

☐ Insulin ☐ Metformin ☐ Other: _____

Are you currently taking any GLP-1 agonists medication? (See list below) ☐ Yes ☐ No

☐ **ADLYXIN** (LIXISENATIDE)	☐ **OZEMPIC** (SEMAGLUTIDE)	☐ **SAXENDA** (LIRAGLUTIDE)
☐ **BYDUREON BCISE** (EXENATIDE SUSPENSION)	☐ **RYBELSUS** (SEMAGLUTIDE)	☐ **TANZEUM** (ALBIGLUTIDE)
☐ **BYETTA** (EXENATIDE)	☐ **WEGOVY** (SEMAGLUTIDE)	☐ **TRULICITY** (DULAGLUTIDE)
☐ **MOUNJARO** (TIRZEPATIDE)	☐ **VICTOZA** (LIRAGLUTIDE)	

5. Allergies / Reactions

☐ No known allergies

☐ Yes – please specify: _____

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6. Anaesthetic or Sedation History

Have you ever had any problems with anaesthetic or sedation?

☐ No ☐ Yes – please describe: _____

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7. GP and Referral Information

GP Name:

Clinic name:

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8. Additional notes:

Patient signature: _____ Date: _____