PATIENT HEALTH QUESTIONNAIRE:

Name: _____ DOB: _____

What is your: **Height:** **cm/ft/ins** **Weight:** **kgs/ibs**

ALLERGIES	**NO**	**YES**	**DETAILS**
Do you have allergies to medications, food, sticking plaster, latex/rubber (e.g. balloons, gloves) or other substances?			
MEDICATIONS	**NO**	**YES**	**DETAILS**
Do you take any anticoagulant, blood–thinning or Diabetic medication? (e.g. Warfarin, Eliquis, Aspirin, Plavix, Fish Oil, Forxiga, Jardiance, Xigduo, Jardiamet, Metformin)			
REGULAR MEDICATIONS not listed above	**Dosage**	**How often**	**Date of last taken**

PREVIOUS OPERATIONS/PROCEDURES	**Year**	**Surgeon**	**Notes**

Do you have, or have you had, any of the following conditions?	**NO**	**YES**	**DETAILS**
Diabetes: Type 1 Type 2			Managed by (please circle): Diet Tablets Insulin
Stroke			Date:
High blood pressure			
Heart attack/ coronary / chest pain/ angina (please circle)			
Blood clots or bleeding disorder?			
Asthma /bronchitis/ pneumonia/ hay fever (please circle)			
Do you have sleep			

apnoea?			
Do you have shortness of breath?			o Walking less than 50 metres o Climbing stairs/ inclines o Lying flat