



BUNBURY ENT

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Experience Quality Care

Patient Health Questionnaire

Patient Name: _____

Date of Birth: _____

Do you have an allergies or sensitivities (medications, tapes, latex, etc)?

Please list below and the reaction you have.

Do you have any medications you take regularly? Please list below and the dosage or ask staff to take a copy of your current medication list.

Please indicate the below that you currently have or have had in the past:

Do you consume alcohol? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, how many per day?
Are you or have you ever been a smoker? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, how many per day or when did you cease smoking? Per day/ Quit:
Do you have obstructive sleep apnoea? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, do you use a C-Pap Machine? No <input type="checkbox"/> Yes <input type="checkbox"/>
Do you have any lung/ breathing conditions (asthma, smoking related, etc)? No <input type="checkbox"/> Yes <input type="checkbox"/> Please Specify:
Do you have diabetes? No <input type="checkbox"/> Yes <input type="checkbox"/> Type: _____ If yes, how is your Diabetes Treated? Diet <input type="checkbox"/> Tablets <input type="checkbox"/> Insulin <input type="checkbox"/>
Do you or do you have a family history of a blood or clotting condition? No <input type="checkbox"/> Yes <input type="checkbox"/> Please specify:
Do you have any heart conditions? No <input type="checkbox"/> Yes <input type="checkbox"/> Please specify: _____ Have you had any heart procedures? No <input type="checkbox"/> Yes <input type="checkbox"/> Please specify:
Do you have any neurological conditions (stroke, seizures, epilepsy, etc)? No <input type="checkbox"/> Yes <input type="checkbox"/> Please Specify:
Do you have any mental health conditions? No <input type="checkbox"/> Yes <input type="checkbox"/> Please Specify:
Do you have any history of cancer? No <input type="checkbox"/> Yes <input type="checkbox"/> Please Specify:

Patient/ Guardian Signature: _____

Date: ____/____/____