SURFCOAST
ENDOSCOPY SERVICES

0481253671
admin@surfcoastendoscopy.com
www.surfcoastendoscopy.com

PATIENT QUESTIONNAIRE

PATIENT DETAILS

Date completed: ____/____/____

Name:	Date of birth:
Address:	Email:
Home/Mobile:	Post Code:
Private Health Insurance:	Membership No:
Appointment Type: ☐ Gastroscopy ☐ Colonoscopy ☐ Both ☐ Consultation	
Medicare & Healthcare Information: ☐ Medicare ☐ Healthcare Card ☐ Pension Card	
Medicare No:	Ref No:
Other:	
Assistance/Special Needs/Mobility concerns:	

ALLERGIES & ADVERSE REACTIONS (If tick 'Yes' please add comment)

Do you have any allergies/reactions?	☐ Yes ☐ No
Do you have any allergies/reactions to food or other substances	☐ Yes ☐ No

MEDICATIONS

Include all prescribed and over the counter medications you currently take in any form (eg tablets, liquid, drops, ointment, puffers, patches, injections, herbal preparations etc)

☐ I have no drug allergies
☐ List any allergies you have (including allergies to drugs)

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MEDICAL HISTORY (Check all that Apply)

- ❑ Adverse reaction to anaesthetic
- ❑ Heart Condition
- ❑ Blood pressure problems
- ❑ Pacemaker orImplantedDefibrillator
- ❑ Blood clot in your lungs or legs
- ❑ Sleep apnoea, disturbed sleep, snoring
- ❑ Lung or breathing problems
- ❑ Shortness of breath with normal daily activities
- ❑ Liver disease or problems
- ❑ Kidney disease or problems
- ❑ Heartburn or reflux
- ❑ Diabetes (Type 1 or Type 2)
- ❑ Epilepsy, fits, blackouts, dizziness
- ❑ Memory problems or dementia
- ❑ Physical disability
- ❑ Fall in the last 3 months
- ❑ Require mobility aids or unsteady on your feet
- ❑ Live in assisted care or nursing home
- ❑ Could you be pregnant
- ❑ Any dental conditions
- ❑ A diagnosis of cancer
- ❑ Visual or hearing aids or prosthesis
- ❑ Current or past smoker (No. per day, Year quit
- ❑ Drink alcohol (Number of drinks per day/week
- ❑ Recreational drugs
- ❑ HIV/AIDS
- ❑ High cholesterol
- ❑ Serious health problems not covered

Details/Other:

DECLARATION OF PATIENT/PARENT/GUARDIAN/LEGAL REPRESENTATIVE

☐ I agree that all information within this form is accurate and true, to the best of my knowledge

☐ I have reviewed the Surfcoast Endoscopy Privacy Policy (SEPP) at **www.surfcoastendoscopy.com/privacy** and I consent to the collection and use of information I provide here and in the course of my engagement with Surfcoast Endoscopy Services.

Full Name: _____ **Relationship to Patient:**_____

Date _____ **Signature**_____

This form must be scanned and emailed to admin@surfcoastendoscopy.com