

Patient Health Questionnaire

Name: _____

Date of birth: _____

Sex: ☐ Male ☐ Female

Height: _____ cm

Weight: _____ kg

Address: _____

Phone number: _____

Date of visit: _____

1. Reason for attendance

Please describe the reason for your visit today.

If you have any symptoms, please state when they started and what they are like.

2. Past medical and surgical history

Have you ever had any significant medical conditions or operations?

If yes, please include the year or your age at the time.

☐ No

☐ Yes (please specify): _____

3. Family medical history

Do any close family members have a history of significant medical conditions (such as heart disease, stroke, diabetes, or cancer)?

☐ No

☐ Yes (please specify below, e.g. Father – hypertension):

☐ Unknown

Please also complete the remaining three pages.

4. Current medication

Are you currently taking any prescribed medication?

☐ No

☐ Yes (please list below or provide your medication record to the reception staff):

5. Non-prescribed products

Do you take any over-the-counter medicines, herbal remedies, supplements, or health products?

☐ No

☐ Yes (please list below):

6. Allergies

a) Food allergies or intolerances

☐ No

☐ Yes (please specify):

b) Other allergies (e.g. pollen, latex)

☐ No

☐ Yes (please specify):

7. Adverse drug reactions

Have you ever had any side effects or allergic reactions to medicines?

☐ No

☐ Yes (please specify the medicine and reaction below):

8. Tests, treatment requests, or concerns

Please tick any that apply and provide details if necessary.

☐ COVID-19 test

☐ Influenza test

☐ Blood tests

☐ X-ray

☐ ECG (heart tracing)

☐ Other tests (please specify):

☐ No tests requested

☐ Medication requested

☐ No medication requested

Please write any concerns you would like to discuss below:

9. Smoking status

☐ Never smoked

☐ Current smoker

Type: ☐ Cigarettes ☐ Heated tobacco products

Amount: _____ cigarettes per day (or _____ packs per day)

☐ Ex-smoker (from age _____ to age _____)

10. Alcohol intake

☐ Non-drinker

☐ Drinks alcohol

Frequency:

☐ Daily

☐ _____ days per week

☐ Occasionally (less than once a week)

☐ Rarely

If applicable, please specify:

- Type of alcohol usually consumed (e.g. beer, wine, spirits):

- Approximate amount per occasion (e.g. number of drinks, glasses, or bottles):

11. Occupation

Occupation (please specify): _____

If applicable, please tick one of the following:

☐ Homemaker

☐ University student

☐ Student (other)

☐ Unemployed

12. Household members

☐ I live alone

☐ I live with others

If you live with others, please provide details of who you live with and their relationship to you below.

13. Driving and safety-critical activities

Please tick if any of the following apply to you.

☐ I do not drive

☐ I drive a car or motorcycle

☐ I drive as part of my job (e.g. company vehicle, bus, train)

☐ I carry out work involving heights or hazardous machinery

14. For female patients only

Are you currently pregnant or breastfeeding?

☐ No

☐ Pregnant (_____ weeks)

☐ Possibly pregnant

☐ Breastfeeding

Thank you for taking the time to complete this form.