Care Gynaecology
Dr Trixie Rasmuson

PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: …… **DOB:** ……..

1. Height: …….. cms Weight: ……..kgs

2. Have you ever been pregnant? ☐ Yes ☐ No

3. When was your most recent pap smear?……

4. Have you ever had an abnormal pap result? ☐ Yes ☐ No

5. Do you have any medical illness? ☐ Yes ☐ No
   If yes, please list ……
   ……
   ……

6. Do you have any of the following?
   - ☐ Heart trouble
   - ☐ High blood pressure
   - ☐ Asthma
   - ☐ Stroke
   - ☐ Diabetes
   - ☐ Epilepsy
   - ☐ Blood clots/DVT's
   - ☐ Hepatitis
   - ☐ Other ……

7. Have you had any operations? ☐ Yes ☐ No
   If yes, please list ……
   ……
   ……

8. Are you currently taking any medication? ☐ Yes ☐ No
   If yes, please list
   ……
   ……
   ……

9. Do you have any allergies to medications? ☐ Yes ☐ No
   If yes, please list ……
   ……
   ……

Patient Signature: …… Date: ……

Updated 16/2/19