Dr Peter Campbell *Urologist*

Patient Health Questionnaire

PATIENT NAME DATE

DATE OF BIRTH AGE

WEIGHT HEIGHT

Can you please list any **major** operations, illnesses or health problems you have had **in the past**.

OPERATIONS / ILLNESS	YEAR

Heart trouble? ☐ NO ☐ YES WHAT & WHEN

High blood pressure? ☐ NO ☐ YES FOR HOW LONG

Blood clots? ☐ NO ☐ YES WHEN

Complications from previous anaesthetic/s? ☐ NO ☐ YES DESCRIBE

Diabetes? ☐ NO ☐ YES ☐ TYPE 1 ☐ TYPE 2 ☐ INSULIN ☐ TABLETS ☐ DIET

Breathing problems? ☐ NO ☐ YES WHAT TYPE

A stroke? ☐ NO ☐ YES WHEN

Do you take other medication to thin your blood (anti-coagulants)? ☐ NO ☐ YES WHAT

HOW OFTEN

Do you smoke? ☐ NO ☐ YES HOW MUCH

Have you smoked in the past? ☐ NO ☐ YES WHEN DID YOU STOP