GASTROENTEROLOGY
CLINICS • QUEENSLAND

Please return to:
DR Natalie Kiel
Fax: 07 3607 2490 or
Email to: reception@geclinicsqld.com.au

CONFIDENTIAL PATIENT QUESTIONNAIRE

Personal details

TITLE: _____ GIVEN NAME: _____ SURNAME: _____

MALE ☐ FEMALE ☐ DATE OF BIRTH: _____/_____/_____

ADDRESS: _____CITY: _____ POSTCODE: _____

CONTACT NUMBERS (HOME) _____ (WORK) _____

(MOBILE) _____

EMAIL ADDRESS: _____@_____ OCCUPATION: _____

NEXT OF KIN: _____ RELATIONSHIP: _____PHONE NUMBER: _____

MEDICARE NUMBER: _____ EXPIRY DATE: _____

PATIENT REFERENCE NUMBER (NUMBER BESIDE YOUR NAME): _____

PRIVATE HEALTH INSURANCE: (YES ☐ / NO ☐)

FUND: _____ MEMBER NO: _____YEAR JOINED: _____

AGED PENSIONER (YES ☐/NO ☐) PENSION NUMBER: _____EXPIRY:____

VETERANS AFFAIRS (YES ☐/ NO ☐) (GOLD ☐ / WHITE CARD ☐)

DVA NO:_____ EXPIRY:_____

REFERRING DOCTOR: _____REGULAR GP: _____

CONSENT ****** Please read carefully as it contains important information********

* I consent to the collection, usage, disclosure and storage of my personal information in accordance with the National Privacy Principles defined under the Privacy Act 2010.
* I understand that I will have to pay for DR Kiel's Doctors services, even if I am admitted to hospital and cared for by another doctor or specialist
* I consent to DR Kiel to share information about my visit to my usual GP.
* I consent to my GP/other doctors sharing information about me with DR Kiel.
* I understand that I am responsible for tests such as X-rays, blood test and other scans.

Patient or Guardian's Signature _____Date: ___/____/_____

Medical history

Please indicate if **you have** or **have had** any of the following (tick and provide details):

Heart problems or Heart Surgery **(chest pain, angina, heart attack, valve disease, heart murmur, irregular pulse, palpitations, stent, bypass surgery, pacemaker, defibrillator, valve replacement)**	**NO** ☐	**YES** ☐	PLEASE DESCRIBE -
High blood pressure	**NO** ☐	**YES** ☐	PLEASE DESCRIBE -
Any serious illness or disabling condition eg: Osteoporosis	**NO** ☐	**YES** ☐	PLEASE DESCRIBE -
Lung problems **(shortness of breath, asthma, bronchitis, COPD, emphysema, sleep apnea, home oxygen, CPAP)**	**NO** ☐	**YES** ☐	PLEASE DESCRIBE -
Diabetes	**NO** ☐	**YES** ☐	☐ INSULIN ☐ TABLETS ☐ DIET-CONTROLLED
Stroke, TIA, epilepsy	**NO** ☐	**YES** ☐	PLEASE DESCRIBE -
Infectious diseases **(hepatitis, jaundice, HIV, tuberculosis)**	**NO** ☐	**YES** ☐	PLEASE DESCRIBE -
Blood clots in legs or lungs **(DVT, PE)**	**NO** ☐	**YES** ☐	PLEASE DESCRIBE -
Kidney problems **(chronic renal failure, dialysis, stones)**	**NO** ☐	**YES** ☐	PLEASE DESCRIBE -
Liver problems **(hepatitis, cirrhosis, jaundice)**	**NO** ☐	**YES** ☐	PLEASE DESCRIBE -
Height: - **cm** **Weight: -** **kg**			

Other medical history

Please tell us a little more about your medical or surgical history.

Have you ever had any surgery?	**NO** ☐	**YES** ☐	
WHAT TYPE OF SURGERY? -			WHEN? -
Have you or your family had any problems with anaesthetic in the past? **(drug reactions, nausea/vomiting, required intensive care)?**	**NO** ☐	**YES** ☐	WHAT? _____
Do you have any visual, hearing, mobility or other impairment?	**NO** ☐	**YES** ☐	**(Eg: Reading Glasses, Hearing Aids)** _____
Do you drink alcohol?	**NO** ☐	**YES** ☐	HOW MANY STANDARD DRINKS PER WEEK? ___
Do you smoke?	**NO** ☐	**YES** ☐	HOW MANY PER DAY? ____
Do you take any blood thinning tablets or have a bleeding tendency? **(anticoagulants, antiplatelets, clotting problems)**	**NO** ☐	**YES** ☐	☐ CLOPIDOGREL (Plavix/Iscover) ☐ WARFARIN ☐ CO-PLAVIX PLEASE TELL US WHY YOU TAKE THIS MEDICINE? _____
Do you take steroid medications **(cortisone, prednisone)**	**NO** ☐	**YES** ☐	PLEASE DESCRIBE –
Do you have any allergies? **(drugs, foods, tapes)**	**NO** ☐	**YES** ☐	PLEASE DESCRIBE -

Medications

Please list all your **current medications** (and bring them on the day of your procedure).

Including Natural Therapies and over the counter medications: -

-

-

-

Gastrointestinal history

Please answer the following specific questions about your gastrointestinal history.

Have you had an upper endoscopy or colonoscopy before?	**NO** ☐ **YES** ☐	☐ **UPPER ENDOSCOPY** ☐ **COLONOSCOPY** **WHEN? -** **WHERE? -**
Do you have reflux symptoms?	**NO** ☐ **YES** ☐	PLEASE DESCRIBE -
Have your bowel habits changed recently?	**NO** ☐ **YES** ☐	PLEASE DESCRIBE -
Have you passed blood or mucus in your stool?	**NO** ☐ **YES** ☐	PLEASE DESCRIBE -
To help us plan your procedure, please tell us about your usual bowel habit.	☐ **Normal** ☐ **Constipated** ☐ **Diarrhoea**	PLEASE DESCRIBE CONSISTENCY AND HOW OFTEN -
Do you take any regular laxatives?	**NO** ☐ **YES** ☐	WHAT DO YOU TAKE? -
Do you have abdominal/belly pain or tenderness?	**NO** ☐ **YES** ☐	PLEASE DESCRIBE -
Do you or your family have any history of bowel cancer?	**NO** ☐ **YES** ☐	PLEASE DESCRIBE -
Do you or your family have any bowel diseases? **(Inflammatory Bowel Disease, Ulcerative Colitis, Crohn's)**	**NO** ☐ **YES** ☐	PLEASE DESCRIBE -
Do you or your family have Coeliac Disease?	**NO** ☐ **YES** ☐	