PATIENT HEALTH QUESTIONNAIRE **Date completed:**

NAME: djflkjsdljk DATE OF BIRTH:

Current Height cm Current Weight kg

Do you smoke? Yes ☐ No ☐ How many cigarettes per day?

Do you drink alcohol? Yes ☐ No ☐ How many standard drinks per week?

ALLERGIES:

Do you have any allergies to Medications? Yes ☑ No ☑

If yes, please specify

Do you have any other allergies (eg. Tapes, food, latex, other)? Yes ☐ No ☐

If yes, please specify

MEDICATIONS:

Do you take any of the following -

Blood Thinning Medication:

Aspirin ☐	Apixaban (Eliquis) ☐	Warfarin (Marevan/Coumadin) ☐
Clopidogrel (Plavix) ☐	Rivaroxaban (Xarelto) ☑	
Enoxaparin (Clexane) ☐	Dabigatran (Pradaxa) ☐	Other (please specify below) ☐

Notes

Diabetic Medication:

Are you Diabetic – Yes ☐ No ☐

If yes, please specify

Insulin ☐ Tablets (please specify below) ☐ Diet Controlled ☐

Diabetic Medication

IMPORTANT - PLEASE SELECT IF YOU TAKE ANY OF THE FOLLOWING ☐Forxiga (dapagliflozin), ☐Jardiance (empagliflozin),☐Jardiamet,☐Xigduo,☐ertugliflozin (Steglatro),☐Segluromet, ☐Gliptins (Glyxambi, Qtern, Steglujan)

Please list any other regular medications – (including herbal remedies and over the counter medications):