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IN CONFIDENCE WHEN COMPLETED

THIS FORM IS TO BE RETAINED BY THE EXAMINING DOCTOR

PATIENT HEALTH QUESTIONNAIRE (Part 1)

(To be completed by patient, Doctor to retain)

Patient Information:

Surname:	**Given Names:**
Address	
Date of Birth	**Phone:**

Person/Company receiving the completed medical:

Person/Company	**Phone:**
Address:	**Fax:**

Instructions for completion:

Please answer the questions by ticking the appropriate box. If you are not sure what a question means, leave the answer blank and the doctor will help you. The doctor will ask you additional questions during the examination. On completion of the questionnaire you will be asked to sign a declaration to confirm the accuracy of your responses.

The details of your health assessment will remain confidential and will only be reported to the person/company you nominate. The examining health professional retains all detailed medical papers including your questionnaire responses and the completed record of clinical findings. The examining health professional will send the completed medical form to the person/company you nominate indicating your fitness for duty classification. Other than the above, your personal information will not be disclosed to any other person or organisation without your written permission, except when required by law.

Patient Declaration:

I have read and understood the above statement concerning the health information provided in this document and hereby give my consent for the examining doctor to release information and any results or reports to the above Person/Company.

Patient Signature	**Date**

Consent to contact treating health professionals:

I consent to the examining doctor contacting my treating health professionals to clarify aspects of my medical management.

Patient Signature	**Date**

Questions:

1. ***Are you currently attending a health professional for any illness or injury? If Yes, give details***

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_____

2. ***Are you taking any regular medication? If Yes give details:***

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Doctor's comments:

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3. ***Do you suffer from or have you ever suffered from any of the following:***

3.1	High Blood Pressure	No Yes	***3.11***	Stroke	No Yes
3.2	Heart disease	No Yes	***3.12***	Dizziness, vertigo, problems with balance	No Yes
3.3	Chest pain, angina	No Yes	***3.13***	Memory loss or difficulty with attention or concentration	No Yes
3.4	Any condition requiring heart surgery	No Yes	***3.14***	Other neurological disorder	No Yes
3.5	Palpitations/Irregular heartbeat	No Yes	***3.15***	Neck, back or limb disorders	No Yes
3.6	Abnormal shortness of breath	No Yes	***3.16***	Double vision, difficulty seeing	No Yes
3.7	Diabetes	No Yes	***3.17***	Colour Blindness	No Yes
3.8	Head Injury, spiral injury	No Yes	***3.18***	Hearing loss or deafness or had an ear operation or use a hearing aid	No Yes
3.9	Seizures, fits, convulsions, epilepsy	No Yes	***3.19***	A psychiatric illness or nervous disorder	No Yes
3.10	Blackouts or fainting	No Yes			

Doctor's Comments:

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4. Have you ever had any other serious injury, illness, operation or accident or been in hospital for any reason? ***No Yes***

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Doctors Comments:

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5. Sleep:

5.1	Have you ever been tested for a sleep disorder r been told by a doctor that you have a sleep disorder, sleep apnoea or narcolepsy?			☐No ☐Yes	
5.2	Has anyone told you that your breathing stops or is disrupted by episodes of choking during your sleep?			☐No ☐Yes	
5.3	How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? *This refers to your usual way of life in recent times. If you haven't done some of these things recently try to work out how they would have affected you.*	***would never doze off (0)***	***slight chance of dozing (1)***	***Moderate chance of dozing (2)***	***High change of dozing (3)***
a	Sitting and reading	☐	☐	☐	☐
b	Watching TV	☐	☐	☐	☐
c	Sitting inactive in a public place (e.g. a theatre or a meeting)	☐	☐	☐	☐
d	As a passenger in a car for an hour without a break	☐	☐	☐	☐
e	Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
f	Sitting and talking to someone	☐	☐	☐	☐
g	Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
h	In a car, while stopped for a few minutes in the traffic	☐	☐	☐	☐

Doctor's Comments:

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6. Alcohol

6.1	Have you ever sought assistance for alcohol or substance use issues?				☐No ☐ Yes	
6.2	***Please circle the answer that best describes your situation***	***(0)***	***(1)***	***(2)***	***(3)***	***(4)***
a	How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week
b	How many drinks containing alcohol do you have on a typical day when you are drinking	1-2	3-5	5-6	7-9	10 or more
c	How often do you have six or more drinks on one	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per

	occasion?					week
d	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week
e	How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week
f	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week
g	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week
h	How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week
i	Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year
j	Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

Doctor's Comments:

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Other

7.	Do you currently use illicit drugs?	☐No Yes
8.	Do you use any drugs or medications not prescribed to you by your doctor?	☐No☐Yes
9.	Have you been in a vehicle crash since your last fitness to drive examination?	☐No ☐Yes

Doctor's comments:

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Patient's declaration-accuracy and completeness of information provided

To the best of my knowledge the answers given above are accurate and complete:

Signature of patient	**Date**

Signature of examining doctor	**Date**