QUINTE ORTHOPAEDICS
& REHABILITATION SPECIALISTS

Patient General Health Questionnaire Date:_____

Name: _____ Date of Birth: _____

1. Do you have any heart problems?	Yes	No
2. Do you have a pacemaker?	Yes	No
3. Do you have any thyroid problems?	Yes	No
4. Do you have HIGH or LOW blood pressure?	Yes	No

5. Are you currently taking any medications? If yes, please list

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6. Have you been diagnosed with arthritis?	Yes	No
7. Do you have diabetes?	Yes	No
8. Do you have or ever had cancer?	Yes	No
9. Have you ever broken a bone?	Yes	No
10. Do you have any metal fixations, plates, screws, etc.?	Yes	No
11. Do you smoke? How much _____	Yes	No
12. Do you have any abdominal problems, i.e. Hernia, ulcer?	Yes	No
13. Have you had any previous surgeries (please list)	Yes	No

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14. If female, are you or could you be pregnant?	Yes	No
15. Have you been involved in a previous car accident?	Yes	No

If yes, date: _____

16. Do you have any allergies, irritations, infections, etc.?	Yes	No
17. Do you have asthma or any respiratory problems?	Yes	No
18. Do you have any other health problems not listed above?	Yes	No
19. Are there any other reasons that you should not do Physical activities?	Yes	No

Emergency contact person: _____ Phone Number: _____

Client's Signature: _____