General Health Questionnaire

ALTA ORTHOPAEDICS

Name:_____ **Date:** _____

What are you being seen for today? _____ ☐ Right ☐Left ☐Bilateral

How long have you had this problem for? _____

Height: _____ **Weight:** _____

Please check if you have any of the following medical conditions:

◯ Cancer	◯ Heart Disease	◯ High Blood Pressure	◯ Arthritis
◯ Asthma	◯ Lung Disease	◯ Fainting spells	◯ Hepatitis
◯ Bleeding problems	◯ Stomach Ulcers	◯ Stroke	◯ Aids/HIV
◯ Kidney Failure	◯ Infection	◯ Gallbladder Disease	◯ Psychiatric Illness
◯ Diabetes	◯ Blood Clot – DVT	◯ Sleep Apnea	

◯ Other: _____

Do any of the above conditions run in your family: ◯ No ◯ Yes

List: _____

Please list all current medications:

_____

_____

_____

Are you currently taking any "blood thinners"? ◯ No ◯ Yes

List: _____

List any allergies to medication: _____

Please list all surgeries you have had:

_____

_____

Please list any other hospitalizations you have had:

_____

_____

Have you or a family member ever had problems with anesthesia? ◯ No ◯ Yes

Do you have or have had low back problems? ◯ No ◯ Yes

Do you smoke? ◯ No ◯ Yes How much? _____

Do you drink alcohol? ◯ None ◯ Rarely ◯ Occasionally ◯ Frequently ◯ Daily

Please check if you have any of the following:

◯ Excessive thirst	◯ Shortness of Breath	◯ Difficulty swallowing	◯ Joint pain
◯ Fainting spells	◯ Cough/wheeze	◯ Frequent stools	◯ Trouble walking or balance

◯ Skin rash	◯ Chest pain	◯ Headaches	◯ Sensory loss or numbness
◯ Bruise easily	◯ Palpitations	◯ Difficulty sleeping	◯ Swelling
◯ Hearing loss	◯ Constipation	◯ Anxiety or depression	◯ Up at night to urinate
◯ Corrective eyewear	◯ Stomach pain	◯ Muscle pain/weakness	◯ Burning with urination