CONFIDENTIAL MEDICAL SCREENING QUESTIONNAIRE

Name: _____ **Date of Birth**: mm / dd / yy

1. Do you presently or have you ever suffered from any of the following? *(Check all that apply)*

- ❑ Heart problems
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Stroke
- ❑ Lung problems
- ❑ Cancer
- ❑ Diabetes
- ❑ Osteoporosis
- ❑ Broken bones / fractures
- ❑ Allergies:_____
- ❑ Arthritis (eg. rheumatoid)
- ❑ HIV / AIDS
- ❑ Kidney problems
- ❑ Repeated infections
- ❑ Thyroid problems
- ❑ Skin disease or sensitivity
- ❑ Depression
- ❑ Asthma
- ❑ Epilepsy / Seizures
- ❑ Hepatitis

2. Have you had any surgeries or major dental work? *(Please list)*

_____ _____

_____ _____

3. Please provide a list of your current medications:

_____ _____ _____

_____ _____ _____

4. Do you smoke? ❑ No ❑ Yes → are you interested in quitting? Yes / No

5. Do you have a pacemaker? ❑ Yes ❑ No

6. Do you suffer from insomnia (disturbed sleep)? ❑ Yes ❑ No

7. Do you feel that you currently have significant stress in your life? ❑ Yes ❑ No

8. FOR WOMEN: Are you currently pregnant or think you may be pregnant? ❑ Yes ❑ No

9. I am **optimistic** that my present problem will improve. *(Please circle one)*

1	2	3	4	5
Strongly disagree	Disagree	No opinion	Agree	Strongly Agree

Signature: _____ **Date**: mm / dd / yy

Thank you for completing this questionnaire. Your information is kept private and confidential.

Patients will have a screening physical prior to their physiotherapy assessment.