Ridgefield Physical Therapy

# General Health Questionnaire

Name: _____ Occupation: _____
Problem/Onset Date: _____

## Medical History: (Check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma/Difficulty Breathing
- ☐ Autoimmune Disease
- ☐ Cancer
  Type: _____
- ☐ Depression
- ☐ Diabetes
- ☐ Dropped Arches/Feet
- ☐ Fainting Spells
- ☐ Fibromyalgia
- ☐ Hearing Impairment
- ☐ Kidney Disease
- ☐ Lung Problems
- ☐ Osteoporosis
- ☐ Radiation Treatment
- ☐ Scar Pain
- ☐ Scoliosis
- ☐ Seizures
- ☐ Smoker
  Current _____
  Past _____
- ☐ Visual Impairment
- ☐ Other: _____

### Heart/Circulation

- ☐ Clotting Disorder
- ☐ Heart Attack/Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pacemaker
- ☐ Stroke
- ☐ Swelling in Limbs

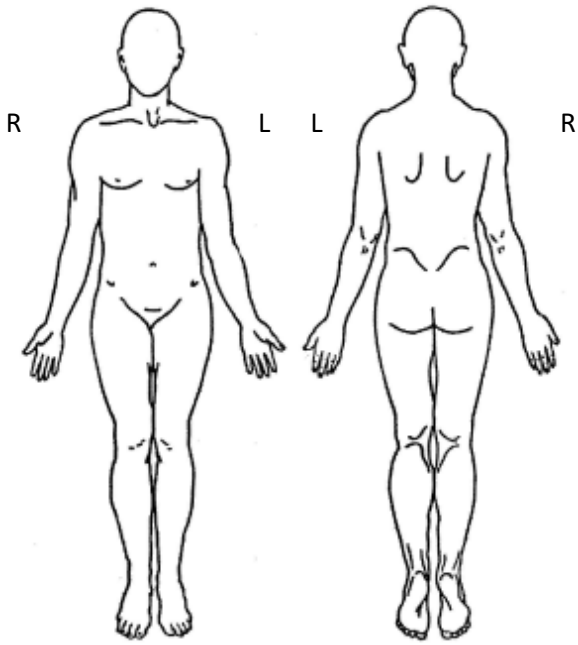
### Pelvic History

- ☐ Digestion Issues/Disease
  Type: _____
- ☐ "Falling out" Feeling
- ☐ Hemorrhoids
- ☐ Hormone Replacement
- ☐ Hysterectomy
  Type: _____
- ☐ Menstrual Pain
- ☐ Pelvic Pain
- ☐ PMS
- ☐ Pregnancy
  Vaginal _____
  C-Section _____
- ☐ Prostatectomy
  Type: _____
- ☐ Urinary/Bowel Leakage
- ☐ Other: _____

## Surgeries (What Kind and When):

- _____
- _____
- _____
- _____
- _____

**Please mark (X) where you feel the most pain:**




## Family History:

- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Attack/Disease
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Psychological
- ☐ Stroke
- ☐ Other: _____

## Medication (Include Dosage and Frequency):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**Patient Signature** _____ **Date**_____