



**Denise Alberto Physical Therapy**

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**General Health History Questionnaire**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Referring Physician: \_\_\_\_\_

Describe the problems for which you seek Physical Therapy Treatment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

When did this problem begin and what was the incidence (what happened)?

\_\_\_\_\_  
\_\_\_\_\_

Have you had this problem before and what treatment have you had in the past?

\_\_\_\_\_  
\_\_\_\_\_

What makes your problem better/worse?

\_\_\_\_\_  
\_\_\_\_\_

Any surgeries in the past?  Yes  No

If yes, please list and date

\_\_\_\_\_  
\_\_\_\_\_

Current list of Medications:

\_\_\_\_\_  
\_\_\_\_\_

Any clinical tests within the past year

\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

**Employment (Check all that apply)**

- Full time                       Part time working                       Work from home  
 Homemaker                       Student                       Retired

**Living Environment (Check all that apply)**

- Stairs     Uneven terrain     Use of assistive devices     Any obstacles

**Assistive Devices (Check all that apply)**

- Cane     Walker     Wheelchair     Glasses     Hearing aides

**General Health Status**

Rate your perception of your health     Poor     Fair     Good     Excellent

List any major life changes or illnesses in the past year. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social/Health Habits**

Smoking: Packs per day \_\_\_\_\_                       Alcohol: Drinks per day \_\_\_\_\_

Sexual Relations:    Pain with intercourse     Abstinence     Frequency \_\_\_\_\_

Family Relations:     Difficulties                       Counseling     Step family

Exercise beyond daily activities and chores. Describe frequency and duration i.e. how many times a week for how many minutes \_\_\_\_\_

**Family History (Check all that apply)**

- Heart Disease     Hypertension     Stroke     Diabetes     Cancer  
 Psychological     Arthritis     Incontinence     Alzheimer's     Osteoporosis  
 Other \_\_\_\_\_

**Medical/Surgical History (Check all that apply)**

- Arthritis     Multiple Sclerosis     Fracture/Osteoporosis     Allergies  
 Blood Disorders     Heart Condition     Diabetes     Head Injury  
 Cancer     Infectious Disease     Kidney problems     Asthma  
 Lung problems     Parkinson Disease     Stomach Problems  
 Low Blood Sugar     Thyroid problems     Vascular Disease

Name: \_\_\_\_\_

**Within the last year have you had any of the following symptoms? (Check all that apply)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Chest pain            | <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Dizziness/blackouts |
| <input type="checkbox"/> Hoarseness            | <input type="checkbox"/> Cough                  | <input type="checkbox"/> Loss of appetite    |
| <input type="checkbox"/> Nausea/vomiting       | <input type="checkbox"/> Rapid weight loss/gain | <input type="checkbox"/> Urinary problems    |
| <input type="checkbox"/> Coordination Problems | <input type="checkbox"/> Blood sugar problems   | <input type="checkbox"/> Bowel Problems      |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Vision disturbances    | <input type="checkbox"/> Difficulty walking  |
| <input type="checkbox"/> Unusual Weakness      | <input type="checkbox"/> Loss of Balance        | <input type="checkbox"/> Pain at night       |
| <input type="checkbox"/> Night sweats          | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Headaches           |
| <input type="checkbox"/> Trouble swallowing    |   |  |

**Current Functional Status (Check all that apply and explain in the space provided)**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Difficulty with bed mobility         | <input type="checkbox"/> Walking difficulty   | <input type="checkbox"/> Loss of balance          |
| <input type="checkbox"/> Transfer problems                    | <input type="checkbox"/> Self care difficulty | <input type="checkbox"/> Home management problems |
| <input type="checkbox"/> Difficulty with community activities |   |   |

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Anything we have missed or that you would like to tell us?

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***MEN ONLY***

Have you ever been diagnosed with prostate disease?  Yes  No

If yes, when \_\_\_\_\_

***WOMEN ONLY***

Have you been diagnosed with any of the following? (Please check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Endometriosis             | <input type="checkbox"/> Complicated pregnancies/deliveries |
| <input type="checkbox"/> Currently pregnant          | <input type="checkbox"/> Trouble with your periods | <input type="checkbox"/> Other gynecological problems       |

OB history (number of vaginal deliveries, c-section, episiotomy, forceps):

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