Clough Family Center for
Rehabilitative and Sports Therapies
at Emerson Hospital

General Health Questionnaire

Name: **Date of Birth:**

Email: **Phone Number:**

Please X next to any condition listed below that you currently have or may have had:

High Blood Pressure: YES☐	Diabetes: YES☐	Pacemaker: YES☐
Heart Attack: YES☐	Frequent Urination: YES☐	Traumatic Brain Injury: YES☐
Stroke: YES☐	Kidney Disease: YES☐	Sleep Disorder: YES☐
Chest Pain: YES☐	Bowel/Bladder Incontinence:YES☐	Depression: YES☐
Angina :YES☐	Painful urination: YES☐	Mental Illness: YES☐
Respiratory Problems: YES☐	Stress Incontinence: YES☐	Parkinson's: YES☐
Asthma: YES☐	Excessive Thirst: YES☐	Polio: YES☐
Shortness of Breath: YES☐	Impaired Vision: YES☐	Scoliosis: YES☐
Lung Disease: YES☐	Impaired hearing: YES☐	Post-Polio: YES☐
Smoking: YES☐	Glasses/Contacts: YES☐	Multiple Sclerosis: YES☐
Persistent Cough: YES☐	History of Cancer: YES☐	Rheumatoid Arthritis: YES☐
Lupus: YES☐	Radiation: YES☐	Osteoporosis: YES☐
Scleroderma: YES☐	Chemotherapy: YES☐	Joint Pain/Stiffness: YES☐
Reynaud's: YES☐	Tumor: YES☐	Arthritis: YES☐
Thyroid: YES☐	AIDS: YES☐	Heartburn/Reflux: YES☐
Osteopenia: YES☐	General Fatigue: YES☐	Fibromyalgia: YES☐
MRSA: YES☐	Headaches: YES☐	Chronic Pain: YES☐
C-Diff: YES☐	Dizziness/Fall: YES☐	Pregnant: YES☐
Abnormal Weight Gain/Loss: YES☐	Difficulty Swallowing/Chewing: YES☐	Menopause: YES☐

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OTHER MEDICAL PROBLEMS (please enter approximate date of diagnosis):

SURGICAL PROCEDURES/HOSPITALIZATIONS (please enter approximate date of diagnosis):

MEDICATIONS:

ALLERGIES: **Latex: YES☐**

Signature : **Date:**