Naturopathic Muscle and Joint Clinic, LLC
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PATIENT HEALTH SURVEY

NAME _____ AGE _____ M_____ F_____DATE _____

ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Have you had?
Childhood
□ Measles □ Mumps □ Chickenpox
□ Congenital Abnormalities □ Rheumatic fever or heart disease
Adult
□ Asthma □ High Blood Pressure □ Cancer (Site_____)
□ Diabetes □ Ulcer or Gastritis □ Thyroid Problems
□ Tuberculosis □ Kidney Problems □ Liver Problems
□ Heart Attack □ Venereal Disease □ Heart Failure
Have you ever had any serious illness? No Yes
Have you ever had a transfusion? No Yes
Have you ever been hospitalized or been under medical care for very long? No Yes
If Yes, for what reason? _____

Most recent vaccinations:
Hepatitis B _____ (date) Flu Vaccine _____(date)
Pneumonia _____ (date) Tetanus _____(date)

OPERATIONS:
Have you ever had any surgery? No Yes
List: □ Angioplasty □ Hysterectomy (If yes, reason_____)
□ Ovaries Removed □ Joint Replacement
□ Gallbladder □ Bypass (If yes, what_____)
□ Other _____

ALLERIGIES

MEDICATIONS

INJURIES:
Have you ever been seriously injured in a motor vehicle accident? No Yes
Have you ever had any head concussions or injuries? No Yes
Have you ever been knocked unconscious? No Yes

SOCIAL HISTORY
Circle One: Single Married Separated
Divorced Widowed Significant other

With whom do you live? _____
Recreational Drug Use? No Yes
Do you have any problems with sexual function? No Yes

Foreign Travel within the last year? _____
Coffee_____Tea_____Colas_____(per day)

Alcoholic Beverages Never_____<1 per week``_____
1 – 5 per week _____ Other _____

Tobacco Never Smoked Quit_____ years ago
Years Smoked_____ Packs per day _____

SOCIAL HISTORY (continued)

Are you employed? Full time_____Part time_____
What is your job? _____

Are you exposed fumes, dust or solvents? _____

How much time have you lost from work because of your health during the past?
Six months_____ One year _____Five years _____
Education (years)
Grade school _____College _____ Postgraduate _____

FAMILY HISTORY	Age	Health	If Deceased Age of Death	Cause of Death
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has either parent, sister, brother or grandparent ever had?

Stroke	No	Yes	Heart Trouble	No	Yes
Tuberculosis	No	Yes	High Blood Pressure	No	Yes
Diabetes	No	Yes			

Has any blood relative had?

Cancer	No	Yes	Bleeding Tendency	No	Yes
Type			Gout or other crippling arthritis		
Suicide	No	Yes		No	Yes
Mental Illness	No	Yes	Hereditary Defects	No	Yes