

NAME: _____ AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____

Street

City

Postal Code

HOME PHONE: _____ WORK PHONE: _____

MARITAL STATUS: S M D W SEP NUMBER OF CHILDREN: _____

REFERRED BY: _____ EMPLOYER: _____

OCCUPATION(S): _____

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE FOR YOU:

COMPLAINT	SINCE	CAUSES

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?:

MEDICATION	SINCE	ADVERSE EFFECTS

WHAT OTHER TREATMENTS OR REGIMES ARE YOU CURRENTLY FOLLOWING?:

TREATMENT OR REGIME	SINCE	RESULTS

WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD?

ABSCESSES	ALCOHOLISM	ALLERGIES	AMNESIA	ARTHRITIS	ASTHMA	CANCER
CHICKEN POX	COLD SORES	DEPRESSION	DIABETES	EMPHYSEMA	EPILEPSY	GALL STONES
GOITRE	GONORRHEA	GOUT	HAY FEVER	HEART DISEASE	HEPATIS	HERPES GENI
INFLUENA	KIDNEY DISEASE	LEUKAEMIA	MALARIA	MEASLES	MISCARRIAGE	MONO
MUMPS	PARASITES	PELVIC INFLAMMATORY DISEASE	PERITONITIS	PLEURSY	PNEUMONIA	PROSTATITIS
RHEUMATIC FEVER	RUBELLA	SUNSTROKE	SCARLET FEVER	SEXUAL ABUSE	SKIN DISEASE	STREP THROAT
TUBERCULOSIS	SINUSITIS	STROKE	SYPHILIS	TONSILLATIS	TYPHOID FEVER	VENEREAL WARTS
WARTS	WHOOPING COUGH	WORMS	YELLOW FEVER			

ANY OTHER MAJOR CONDITIONS? _____

ARE THERE ANY OF THE PRECEDING CONDITIONS AFTER WHICH YOU HAVE NOT BEEN TOTALLY WELL AGAIN, OR WHICH HAVE BEEN MORE SEVERE THAN USUAL? WHICH ONES? _____

WHAT OPERATIONS HAVE YOU HAD?

OPERATION	WHEN	COMPLICATIONS

WHAT MAJOR INJURIES HAVE YOU HAD?

INJURY	WHEN	LONG TERM EFFECTS

AGE OF FIRST MENSES: _____ **NUMBER OF PREGNANCIES:** _____

WHAT VACCINATIONS HAVE YOU HAD: _____

ANY ADVERSE EFFECTS FROM THEM? _____

HAVE YOU LOST ANY WEIGHT LATELY? HOW MANY POUNDS? _____

WHAT EXERCISE DO YOU DO AND HOW MUCH? _____

HOW MUCH OF THE FOLLOWING SUBSTANCES ARE YOU USING?

TOBACCO:	ALCOHOL:
COFFEE:	RECREATIONAL DRUGS:

INDICATE BELOW WHICH OF THE FOLLOWING AILMENTS OR ANY OTHER MAJOR AILMENTS, HAVE AFFECTED YOUR RELATIVES:

ALCOHOLISM ALLERGIES ARTHRITIS	ASTHMA CANCER DEPRESSION	DIABETES EPILEPSY GONORRHOEA	GOUT HAY FEVER HEART DISEASE	INSANITY PARALYSIS PNEUMONIA	SKIN DISEASE SYPHILIS TUBERCULOSIS
RELATIVE	AGE IF ALIVE	AGE AT DEATH	AILMENTS		
MOTHER:					
FATHER:					
BROTHER:					
SISTERS:					
CHILDREN:					
MATERAL GRANDMOTHER:					
MATERNAL GRANDFATHER:					
MATERNAL AUNTS/UNCLES:					
PATERAL GRANDMOTHER:					
PATERNAL GRANDFATHER:					
PATERNAL AUNTS/UNCLES:					

ARE YOU CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN(S)?

PHYSICIAN	FOR WHAT CONDITIONS	TREATMENTS

HAVE YOU BEEN TREATED WITH HOMEOPATHY BEFORE?

PHYSICIAN	FOR WHAT CONDITIONS?	WHEN?