

- PATIENT HISTORY -

Date: _____

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Marital Status: Single Divorced Widowed

Date of Birth: _____ Age: _____ M F _____

Weight: _____ Height: _____

Number of Children: _____ Number of Pregnancies: _____

Age at First Menses _____

Occupation: _____

Emergency Contact Name: _____

Referred By: _____

What are your main concerns in order of priority? Since when?

Are you currently taking any medications or supplements? For how long?

Can you trace the origin of your illness to any particular circumstances, accident, illness, incident or mental upset (e.g. shock, worry, dietary, overexertion, weather?)

Please indicate (mark with a "✓") which one of the following substances you use.

- | | |
|---|-----------------|
| <input type="checkbox"/> Alcohol | how much? _____ |
| <input type="checkbox"/> Chewing Tobacco | how much? _____ |
| <input type="checkbox"/> Cigarettes | how much? _____ |
| <input type="checkbox"/> Coffee | how much? _____ |
| <input type="checkbox"/> Laxatives/Purgatives | how much? _____ |
| <input type="checkbox"/> Pain killers | how much? _____ |
| <input type="checkbox"/> Recreational Drugs | how much? _____ |
| <input type="checkbox"/> Sleeping Pills | how much? _____ |
| <input type="checkbox"/> Supplements/Herbs | how much? _____ |
| <input type="checkbox"/> Tea | how much? _____ |

Please indicate (mark with a "✓") which one of the following ailments you have experienced or are suffering from now.

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Goitre | <input type="checkbox"/> Gonorrhoea |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Heart Dx. |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Insanity | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Kidney Dx. | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Liver Dx. |
| <input type="checkbox"/> Malaria | <input type="checkbox"/> Measles | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Mono. | <input type="checkbox"/> Mumps | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Parasites | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Rheum. Fev. | <input type="checkbox"/> SexualAbuse |
| <input type="checkbox"/> Skin Dx. | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Tonsilitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Urticaria | <input type="checkbox"/> Venerealwarts |
| <input type="checkbox"/> Warts | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Worms |
| <input type="checkbox"/> Yellow fever | | |

Please list any major surgeries you have had in the past?

Have you had any injuries?

What vaccinations have you had? Did you or do you have any adverse reactions?

Have you lost weight recently? How much?

Please indicate (mark with an "✓") which one of the following ailments is present in your family history?

- Alzheimers Alcoholism Cancer Diabetes Depression
 Gonorrhoea Hypertension Heart Dx. Hepatitis Insanity
 Skin Dx. Syphilis Tuberculosis

RELATIONSHIP	AGE	AGE AT DEATH	CAUSE OF DEATH	DISEASES
FATHER				
PATERNAL GRANDFATHER				
PATERNAL GRANDMOTHER				
MOTHER				
MATERNAL GRANDFATHER				
MATERNAL GRANDMOTHER				
SISTER(S)				
BROTHER(S)				
AUNT(S)				
UNCLE(S)				

Please list the name and phone number of your family physician?

Have you been treated by a Homeopath before? If yes, what is his/her name?
